DOCUMENT RESUME

ED 113 662 CG 010 166

TITLE	Rehabilitation of the Severely Disabled. Eleventh Institute on Rehabilitation Services. A Training Resource.
INSTITUTION	West Virginia Univ., Morgantown. Regional Rehabilitation Research and Training Center.
SPONS AGENCY	Social and Rehabilitation Service (DHEW), Washington, D.C.
PUB DATE	May 73
NOTE	105p.; Paper presented at the Institute on Rehabilitation Services (11th, New Orleans, Louisiana, May 20-23, 1973)
EDRS PRICE	MF-$0.76 HC-$5.70 Plus Postage
DESCRIPTORS	Evaluation Methods; Guidelines; *Handicapped; Program Descriptions; *Program Development; *Rehabilitation Counseling; Resource Materials; *Severely Handicapped; Social Services; *Vocational Rehabilitation
IDENTIFIERS	*Conference Report HR 8395

ABSTRACT

One of the significant results of the 92nd and 93rd Congresses was the statement in the Conference Report: H.R. 8395 clarifying the roles to be played by the federal state grant-in-aid program for vocational rehabilitation. The Conference Report states that the order of selection be modified to require serving first those individuals with the most severe handicaps. The severely disabled and the severely handicapped populations should be the first priority of vocational rehabilitation programs. The challenge is to find means to pursue the objective in ways that work. This publication attempts to describe an intense program of vocational rehabilitation services in which time, money, and effort are spent in ascertaining what reasonably can be expected to improve the severely disabled and severely handicapped's ability to live independently and function within a vocational setting. It is intended to provide a practical training guide that will be helpful in the development of programs and for the provision of services to the severely disabled. (Author)

****
* Documents acquired by ERIC include many informal unpublished *
* materials not available from other sources. ERIC makes every effort *
* to obtain the best copy available. Nevertheless, items of marginal *
* reproducibility are often encountered and this affects the quality *
* of the microfiche and hardcopy reproductions ERIC makes available *
* via the ERIC Document Reproduction Service (EDRS). EDRS is not *
* responsible for the quality of the original document. Reproductions *
* supplied by EDRS are the best that can be made from the original. *
****

ED113662

REHABILITATION OF THE SEVERELY DISABLED

ELEVENTH INSTITUTE ON REHABILITATION SERVICES

U S DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

a training resource

CE 010 166

Sponsored by
West Virginia University
Rehabilitation Research and Training Center

REHABILITATION OF THE SEVERELY DISABLED

A Report from the Study Group on Rehabilitation of the Severely Disabled

Chairman
Adam Zawada
Tallahassee, Florida

ELEVENTH INSTITUTE ON REHABILITATION SERVICES

May 20 - 23, 1973
New Orleans, Louisiana

University Sponsor

RESEARCH AND TRAINING CENTER
INSTITUTE, WEST VIRGINIA 25112

This publication was supported in part by Research and Training Center Grant RT-15 from the Social and Rehabilitation Service, Department of Health, Education and Welfare, Washington, D. C., to West Virginia University and the West Virginia Division of Vocational Rehabilitation.
The material may be quoted or reprinted without formality other than the customary acknowledgment of the R and T Center.

FOREWORD

Congressional hearings last year on vocational rehabilitation legislation clearly reflected the great degree of interest in the provision of more and better services for the severely disabled. Congress itself, more than ever before, expressed the conviction that there should be a substantial increase in the number of severely handicapped persons served in the State-Federal program.

Planners for the Eleventh Institute on Rehabilitation Services, in a timely decision, selected the severely disabled as a topic for one of the prime study groups.

This training guide represents the combined thinking of numerous persons in the State-Federal program and the universities.

A conscientious effort has been made to provide a practical training guide that will be helpful in the development of programs and for the provision of services to the severely disabled.

Corbett Ready
Acting Commissioner
Rehabilitation Services Administration

PREFACE

During the past fifty years Vocational Rehabilitation programs have operated as competitors. In lean budget years, the competition was for survival and maintenance of effort; the more affluent years brought an eagerness to compete for mandates, to accept new responsibilities and enlarge the traditional territory of the program.

One of the significant results of the 92nd and 93rd Congresses was the statement in the Conference Report: H.R. 8395 – clarifying the roles to be played by the Federal-State grant in-aid program for Vocational Rehabilitation. The Conference Report states that the order of selection be modified to require serving first those individuals with the most severe handicaps. (1)

There has never been a more appropriate time than now to clear up the confusion of role ambiguity and overlap in Vocational Rehabilitation programs.

The severely disabled and the severely handicapped populations are indeed the first priority of Vocational Rehabilitation programs. The challenge is to find means to pursue the objective in ways that work.

This publication attempts to describe an intense program of Vocational Rehabilitation services in which time, money, and effort are spent in ascertaining what reasonably can be expected to improve the severely disabled and severely handicapped's ability to live independently and function within a vocational setting.

REFERENCES

1. U.S., Congressional Record, 92nd Congress, 2nd Session (1972), Conference Report on H.R. 8395, October 14, 1972.

TABLE OF CONTENTS

	Page
Chapter 1 – REHABILITATION AND THE SEVERELY DISABLED	1
Changing Concepts in Rehabilitation	1
Definitions of Severely Disabled	2
Potential Client Population	4
Current Services to the Severely Disabled	4
Distinction Between Severe Disability and Severe Handicap	7
Requirements to Serve Severely Handicapped Persons	8
Chapter 2 – RESOURCE UTILIZATION	11
Referral	11
Case Development and Initial Evaluation	11
Comprehensive Rehabilitation Evaluation	12
Medical Aspects	13
Psychological Factors	15
Sociocultural Factors	16
Transportation Needs	16
Housing Needs	17
Summary	19
Planning and Providing Services	21
Use of Volunteers in Providing Services to the Severely Handicapped	22
Client Role	24
Follow-along	24
Chapter 3 – EXTENDED EVALUATION	27
Historical Background	27
Importance	31
Components in Extended Evaluation	32
Costs for Diagnosis and Evaluation	34
Role of the Rehabilitation Counselor	35

	Page
Chapter 4 – CONSIDERATIONS IN MEASUREMENT	37
Case Difficulty	37
Client Change	37
Closure Status	37
Measurement System	39
Client Functioning and Severity of Disability	39
Client Change	40
Actuarially Approach to Measurement and Casework Difficulty	44
Potential Use	45
Problems	47
Getting Down to Particulars	47
Client/Case Performance and Evaluation	52
Other Uses Derived From a Comprehensive Measurement System	53
Appendix A	55
Legislative History Development to Severely Disabled	55
Appendix B	61
Excerpts from Congressional Testimony	61
Appendix C	65
Measurement of Client Change and Level of Functioning	65
Appendix D	87
Members of the Prime Study Group I	87
Appendix E	89
Members of Total Study Group I	89

CHAPTER I

REHABILITATION AND THE SEVERELY DISABLED

From its inception in 1920, we have seen the State/Federal Vocational Rehabilitation program grow and mature in numbers served from less than 1,000 rehabilitations in 1921 to over one third of a million in 1972. The scope of persons served has been broadened from primarily orthopedically and neuromuscularly disabled to include the mentally retarded and mentally disabled. Available services have been refined from job training and provision of prosthetic devices to sophisticated diagnostic and treatment procedures, extended evaluation, personal adjustment training, adapted housing, and an evolved concept of acceptable client-program goals.

The Vocational Rehabilitation program's emphasis on work, though expanded, has been constant from the outset. From the beginning of the program to the present, competitive employment has been the main theme of the program. Homebound employment, sheltered work, and homemaking have now been accepted as valid program goals but this has not always been the case. The by-product of the work goal, with deliberate intent, has been independence and self-sufficiency.

Changing Concepts in Rehabilitation

In the early years, proposals for Vocational Rehabilitation reflected little concern for the handicapped who could not become employable. "Dependency was another matter, still seen as a moral issue, as a private family matter, or a case for private philanthropy, and dealt with by society only when the conditions of dependency become conspicuous and publicly offensive. The public provisions which were made for various kinds of dependency were all similar; incarceration in public institutions maintained at the least possible expense and isolated by distance or high walls from the 'good society'." (2)

Statistical data show the extent to which the program is now serving a population markedly different from earlier years. (5, 6)

. . . . . During the 20's and 30's, 75% of those rehabilitated were disabled from amputations or other orthopedic impairments. In Fiscal Year 1970, only 17.3% of all persons rehabilitated had an orthopedic impairment as the primary disability.

. . . . . Since the Enactment of the 1943 Vocational Rehabilitation Amendments, which provided for physical restoration services and extended services to the mentally ill and mentally retarded, the number of mentally disabled clients rehabilitated has risen steadily to over 93,000 in Fiscal Year 1970, or 36.8% of all persons rehabilitated in that year.

. . . . . Tuberculosis was a relatively prominent disabling condition in the mid-1950's. Today the percentage of rehabilitated clients disabled by tuberculosis is less than 2%.

For more detailed information on legislative history relevant to the severely disabled, see appendices A and B.

Definitions of Severely Disabled

Committee hearings of the 92nd Congress on Vocational Rehabilitation legislation emphasized the difficulty in developing a workable definition of the term "severely handicapped." During Senate hearings, E. B. Whitten pointed out that the determination of the severity of disability, in addition to the measurement of physical function, must consider the cultural level, the family circumstances, the educational level and other factors which aid in assessing the person's ability or inability to function. (2)

The term "severely handicapped individual" means any handicapped individual whose ability to engage in gainful employment, or whose ability to function normally and independently in his family or community, is so limited by the severity of his disability that vocational or comprehensive rehabilitation services appreciably more costly and of appreciably greater duration than those vocational or comprehensive rehabilitation services normally required for the rehabilitation of a handicapped individual are required to improve significantly either his ability to engage in gainful employment or his ability to function normally and independently in his family or community.

The term "State" includes the District of Columbia, the Virgin Islands, Puerto Rico, Guam, American Samoa, and the Trust Territory of the Pacific Islands, and for the purposes of American Samoa and the Trust Territory of the Pacific Islands, the appropriate State agency designated as provided in section 101 (a) (1) shall be the Governor of American Samoa or the High Commissioner of the Trust Territory of the Pacific Islands, as the case may be.

The term "vocational rehabilitation services" means those services identified in section 103 which are provided to handicapped individuals under this Act.

In House legislation, the definition was expressed in functional terms. The individual is "(1) under a physical or mental disability so severe that it limits substantially his ability to function in his family and community as one without such serious disability may be expected to function, and (2) who, with the assistance of comprehensive rehabilitation services can reasonably be expected to improve substantially his ability to live independently and function normally in his family and community." (3)

The differences were reconciled in conference by referring to handicapped individuals with "the most severe handicaps." The term severe handicap was defined to mean "a disability which requires multiple services over an extended period of time resulting from blindness, cancer, cerebral palsy, cystic fibrosis, deafness, heart disease, hemiplegia, respiratory or pulmonary dysfunction, mental retardation, multiple sclerosis, muscular dystrophy, neurological disorders (including stroke and epilepsy), paraplegia, quadraplegia, and other spinal cord conditions, renal failure, and any other disability specified by the Commissioner in regulations he shall prescribe." (2)

The inherent weakness in definition by disability category is due to the wide range of functional limitations caused by a particular disability. As an example, certain individuals with cerebral palsy may experience few, if any, significant limitations; others may be confined to a wheel chair and have a profound speech problem.

Potential Client Population

In Senate hearings, the Rehabilitation Services Administration was asked to estimate the total dollar amount needed to serve all potential clients. Subsequently, the agency provided the following data:

"Recently available data from the 1970 census indicates a potential VR universe of 7 million persons. The total cost for services for this number is estimated to be $13 billion, computed as follows:

	Billions
6 million persons at $2,000	$12
1 million persons at $1,000	1
Total	$13

"The larger number of disabled persons are those who would have vocational potential and would receive all services necessary to prepare them for a gainful occupation. The smaller number would be assisted to improved living status at a lesser cost." (2)

Current Services to the Severely Disabled

The Senate Subcommittee on the Handicapped requested an estimate of the number of severely disabled persons who are rehabilitated by the State Vocational Rehabilitation Agencies. The following information was provided by the Rehabilitation Services Administration (2):

"Severity of disability must be assessed in relationship to all of the factors that impinge on the individual—such as physical or mental, social, economic, educational, age, sex, and race—as well as the environmental variables operative in his immediate situation—such as services available, general economic conditions, climate, transportation, and type of employment opportunities.

"Even given these factors, some physical or mental conditions are more handicapping than others. In order to give some idea of the extent to which individuals with particular physical or mental limitations are being served, the attached chart was developed from data routinely reported by the State vocational rehabilitation agencies at the time the case is closed. These data reflect the

abstract physical or mental status of the individual, and do not take into account the other personal and environmental qualities that might be affecting the individual. Hence, the data are probably a very conservative estimate of the numbers of severely disabled served.

"These data do not reflect the cause of the physical or mental limitation. For example, an individual with cerebral palsy may be recorded as having three or more limbs affected, or one lower and one upper extremity involved, etc., depending on the actual limitation. Further, the data does not accurately reflect multiple problems, but only the major disabling condition, so that if a person were both blind and mildly mentally retarded, for example, he would probably be recorded as blind, in a subjective estimate by the counselor of which was the greater disabling condition."

Disability	Codes	Rehabilitation, FY 1970 Number	Percent
Blindness, both eyes	.....	7,364	2.9
Deafness	.....	5,915	2.3
Orthopedic	.....	13,210	5.1
1. Involvement of three or more limbs or entire body	.....	3,915	1.5
2. Involvement of one upper and one lower limb	.....	3,375	1.3
3. Involvement of one or both upper limbs	.....	5,920	2.3
Amputations	.....	2,114	0.8
1. Loss of at least one upper and one lower major extremity	.....	247	0.1
2. Loss of both major upper extremities	.....	103	(1)
3. Loss of one major upper extremity	.....	1,764	0.7
Psychotic disorders	.....	16,089	6.3
Alcoholism	.....	11,120	4.3
Drug Addiction	.....	832	0.3
Mental retardation, severe	.....	2,299	0.9
Laryngectomies	.....	220	0.1
Leukemia	.....	18	(1)
Emphysema	.....	569	0.2
Pneumoconiosis and absestosis	.....	16	(1)
Total	.....	59,766	23.3

(1) Less than 1%.

The number of severely disabled rehabilitated in 1970 represented approximately 25% of the total. Rehabilitation Services Administration representatives said a higher target close to 40% would be established. It was also stated that the Department wanted to "overcome the tendency to make the numbers look as good as possible in the existing program by instituting a new weighted case closure system, which will give greater credit to an agency which undertakes a difficult case than it would if it undertook an easier case." (2)

Distinction Between Severe Disability and Severe Handicap

Hamilton aptly stated in 1950, "A disability is a condition of impairment, physical or mental, having an objective aspect that can usually be described by a physician. It is essentially a medical thing. A handicap is the cumulative result of the obstacles which disability interposes between the individual and his maximum functional level." (1) Otherwise stated, a condition which can be labeled "disability" does not necessarily constitute a "handicap".

It is necessary to have some common understanding about the concept of severe disability. Disability can be considered as a form of inability to perform roles and tasks required or expected within one's social and physical environment. These roles and tasks tend to cluster into areas of human activity such as self-care, mobility, work, social relations and recreation. Severe is a comparative term which represents the degree of limitation or inability to meet the physical, mental, or other demands of these roles and tasks.

All too frequently the terms "handicapped" and "disability" are interpreted as synonymous and used interchangeably. It is most important that a clear distinction be made between these two terms.

The Vocational Rehabilitation program for many years has been operating under an evaluation model emphasizing the rehabilitation process, namely client study from the medical, psychological, sociocultural, and vocational point of view. Therefore it is suggested that counselors evaluate handicaps in the light of specific limitations to the four client study areas: limitations imposed by the disability (medical and biological), those imposed by the individual on himself (psychological), those imposed by societal forces (sociocultural) and by the work environment (vocational).

It is recognized that severity of disability correlates highly with severity of handicap. But the same biological disability visiting itself upon two individuals may manifest itself to one individual as merely an inconvenient annoyance which is easily overcome. To another individual, this same disability could entirely disrupt and uproot his total existence. Otherwise stated, two individuals may have the identical medically diagnosed condition; both are disabled but both are not necessarily handicapped.

Conversely someone might be only moderately disabled from a medical standpoint but by virtue of concomitant (psychological, sociocultural and vocational) factors this individual might be severely disabled.

Therefore, we can define the term severely handicapped as a person who is so specifically limited as to prevent him from engaging in vocational endeavors, without the provision of intensive and extensive rehabilitative services.

Requirements to Serve Severely Handicapped Persons

The report of the National Citizens Advisory Council on Vocational Rehabilitation emphasized the fact that "many disabled individuals are not receiving the services they desperately need to permit them to become independent, self-respecting citizens" (4). Although the dimension of the unmet need is not precise, there is widespread agreement that much more needs to be done to serve the severely handicapped than has been done. The importance of more funds for the purchase of services is generally accepted. There are many other important factors, however, that influence the number and kinds of severely handicapped persons that can be served. These additional factors include:

1. Monetary factors

   The existence of an inadequate funding base to implement a program of Vocational Rehabilitation services for the severely disabled. A formula funding grant specifically earmarked to extended evaluation may be the answer to that problem.

   Availability of good rehabilitation facilities.

2. Agency and organizational factors

Adequate number of well-trained rehabilitation personnel.

Effective job development and placement activities.

Research and demonstration projects to constantly find better ways to serve the needs of handicapped persons.

3. Community factors

Removal of architectural barriers.

Employer and community attitudes toward the handicapped.

Good transportation facilities.

The capability of the State Rehabilitation Agency to provide the client with the services he needs, when he needs them, and in the appropriate amount, order, and quality.

4. Philosophical factors

Attitude of some administrators and supervisors of State Rehabilitation Agencies.

Attitude of some rehabilitation counselors.

REFERENCES

1. Hamilton, Kenneth W., Counseling the Handicapped in the Rehabilitation Process. New York: Ronald Press Company, 1950.

2. U.S., Congress, Senate, Committee on Labor and Public Welfare, Subcommittee on the Handicapped, Rehabilitation Act of 1972, Hearing, 92nd Congress, 1st and 2nd Sessions (1972) on H.R. 8395.

3. U.S., Congressional Record, 92nd Congress, 2nd Session (1972), Conference Reports on H.R. 8395, October 14, 1972.

4. U.S., Department of Health, Education and Welfare, Report of the National Citizens Advisory Council on Vocational Rehabilitation, Washington, D. C., 1968.

5. U.S., Department of Health, Education and Welfare, Rehabilitation Services Administration, Caseload Statistics – State Vocational Rehabilitation Agencies, Annual Reports, Fiscal Years 1969 and 1970.

6. U.S., Department of Health, Education and Welfare, Rehabilitation Services Administration, Statistical History – Federal-State Program of Vocational Rehabilitation, 1920 - 1969. Washington, D. C., 1970.

CHAPTER 2

RESOURCE UTILIZATION

The traditional rehabilitation system is familiar to most people who will use this document. No attempt will be made to restate the system, but this chapter will hopefully highlight and emphasize certain system components that will be essential if services to the severely handicapped are to be improved and expanded.

Referral

The present referral method available to most State Rehabilitation Agencies can serve as a basis upon which to build a more sophisticated and comprehensive intake system. An inter-agency referral network should be developed that will encompass the state health, welfare and social agencies in such a manner that a referral to one is automatically routed to the appropriate agency or agencies. Volunteer agencies, civic clubs, service clubs, similar organizations and agencies should also be included in this referral network.

A uniform state-wide system for the reporting by hospitals, doctors and other medical personnel must be encouraged to cover certain catastrophic disabilities such as spinal cord injury, renal failure, total deafness, major heart attacks, blindness, etc. In those areas where trauma centers have been established, these too should be considered part of the referral network.

Case Development and Initial Evaluation

This phase of the service delivery system will basically be the same for both the client who has apparent vocational potential and those with disabilities so severe that vocational potential is uncertain.

Those clients with vocational potential will be integrated into the rehabilitation process and the normal case flow will follow. However, the severely handicapped will require a more extensive evaluation to truly assess ultimate vocational potential.

At this stage in the rehabilitation process, the counselor must exercise extreme caution and care not to exclude those cases which appear to have little vocational potential. At this point in the case flow, a client should undergo a comprehensive medical, vocational, psychological and sociocultural evaluation to determine eligibility. The counselor also has the choice of considering extended evaluation and this should be used if there appears to be a chance that a rehabilitation objective could be determined. Program data has shown that extended evaluation has been used in a limited manner by Vocational Rehabilitation programs. (1)

COMPREHENSIVE REHABILITATION EVALUATION

This phase of the delivery system should be considered one of the most important especially where extensive evaluation services may be needed to determine vocational potential. The rehabilitation counselor must determine the information needed and what will constitute a comprehensive evaluation for each specific client.

One of the questions which must be addressed is whether services for the severely handicapped should be handled by "generalists" or by "specialists."

One approach to serving severely handicapped individuals could involve the use of a highly trained and experienced counselor, one who would be particularly astute in recognizing the needs and in delivering the appropriate services. Under this approach each district might have such a counselor who would not only provide direct counseling services to his own caseload, but also be used as a resource person and provide technical consultation to other counselors within the district who have severely handicapped persons in their caseloads. He would be particularly sensitive to the needs of the severely handicapped client and thoroughly knowledgeable about current community facilities at the disposal of these clients.

Such a counselor, like any other effective helper, should have certain skills and abilities: knowledge of medical aspects, understanding of the social factors in disability, vocational considerations, group processes, psychological behavior associated with certain severe handicaps,

interviewing skills, ability to empathize and establish rapport, and the ability to establish a truly helpful counseling relationship. Of paramount importance is a value system based on respect for individual dignity and individual differences.

Though comprehensive evaluative services may differ from client to client or from area to area, there are certain basic dimensions that must be carefully assessed in order to obtain a clear profile of the severely handicapped. The most significant dimensions are: the medical aspects, psychological factors, sociocultural, as well as vocational considerations. These factors have heavy import on the achievement of a satisfactory level of life adjustment for the severely handicapped individual. New counselor attitudes and a change in agency philosophy may be necessary to provide services to this population. The following briefly sets forth the importance of each of these factors and their relevancy in the rehabilitation process.

Medical Aspects

Thorough and appropriate medical examinations are essential to the rehabilitation process. When talking about the severely disabled, this area needs to be particularly underscored and emphasized. The complexity of the medical problems among the severely disabled often requires evaluation beyond what is traditionally regarded as a general medical examination, and is referred to below as a comprehensive medical evaluation. Ideally, through medical diagnosis, we can obtain comprehensive objective information concerning the client's limitations and potentials. From this starting point, we can begin to formulate realistic judgments regarding feasibility as well as possible goals (medical, social and other) for the client.

The medical examination is useful also in bringing to light other medical problems about which the client may be unaware. The counselor can learn whether or not the condition is amenable to treatment and how much progress can reasonably be expected from such treatment.

Psychiatric and psychological examinations can offer significant insight into the client's emotional state and intellectual ability. These factors will be important in determining the client's ability to follow through with a planned rehabilitation program. The degree of client

cooperation and his ability to work actively with the counselor in formulating goals is a major ingredient in a successful rehabilitation program.

The counselor should supply the physician with background information on the client and, if possible, a tentative projection concerning a rehabilitation program for the client. The physician or the medical team should provide the counselor medical information including: history, diagnoses of primary and secondary disabilities, limitations in activities of daily living, prognosis for improvement, and projected need for medical treatment and management. The need for prescribed drugs, prostheses, surgery, and other medically related items should also be provided by the physician. Armed with such comprehensive medical information, the counselor can map out with a high degree of certainty specific goals with his client. He knows where the client stands medically, and can make judgments as to what can be reasonably expected of him in the future.

Ideally, many severely disabled clients should be evaluated as residents in a comprehensive rehabilitation facility due to the severity of their conditions. A comprehensive medical evaluation should include a complete medical work-up and an evaluation of the client's ability to carry out his activities of daily living. For example, can a client adequately manipulate his wheelchair? Is he capable of self care? Does he need physical therapy? Occupational therapy? Further, a planned program, from a medical standpoint, can be established setting attainable medical goals. To answer questions like these, qualified medical opinions are obviously required.

Such comprehensive evaluation can also reveal a good deal about the client's emotional adjustment, e.g. willingness to work with staff, degree of cooperation, etc.

Three distinctive aspects of the counselor's role should be highlighted:

1. The usual role of service coordination.

2. Liaison between client and evaluation staff.

3. Responsibility for initiating and maintaining a good, solid working relationship with client and comprehensive evaluation staff.

The physician is the key member of the team when medical evaluation is the primary concern. It is the physician who will make the final judgments as to the client's medical condition, the possibility for improvement, and the means by which to obtain that improvement. He is most likely the individual who will interpret these findings to the client having previously discussed the findings with the counselor.

The physician and the counselor should have a mutual understanding of the referral process and the method of determining feasibility of the client for services. This flow of information between counselor and the physician is vital, not only in avoiding medically non-feasible referrals, but in keeping the counselor thoroughly and currently informed about the condition of each of his clients. The client may at times identify more closely with the counselor than with the physician and, therefore, the counselor may from time to time be called upon to assist in the area of explaining medical findings. A breakdown in communication between the counselor and physician can bring the wheels of the rehabilitation process to a grinding halt.

Psychological Factors

Frequently we encounter clients whose most handicapping condition is a psychological reaction arising from the primary physical problem. Psychological maladjustment can be the most difficult barrier to overcome in a rehabilitation program. To varying degrees, we can expect that most clients who are severely handicapped will come to us with some measure of psychological disturbance.

During the initial evaluation, the counselor will wish to determine the level of the individual's emotional adjustment. First, the counselor should ascertain an adequate picture of the client's ego strengths, revealing his attitudes towards himself, and his life roles as he now perceives them in his disabled state. Such things as the client's body image, awareness and acceptance of his condition, are important factors. He may employ certain psychological defense mechanisms in order to assist him in coping with the enormity of his situation. Defense mechanisms in themselves are not necessarily harmful unless they are used to such an extent that they significantly distort reality and impede the progress of the rehabilitation process.

It is, therefore, necessary that the client undergo intellectual-cognitive evaluation as well as personality assessment. These will give the counselor a profile of the client's functional level as well as a measure of resources which he might have available to him to deal with the various dimensions of adjustment.

Sociocultural Factors

Frequently the physically disabled individual is socially undesirable, especially if his disability is unsightly. The disabled person will have to struggle with this state of affairs in order to achieve maximum adjustment. Unless the client is convinced that he is OK, it will be virtually impossible for him to overcome the attitudinal barriers in others. Beyond this, the client must develop the means to cope with the reactions of those around him toward his disability.

The adjustment problems relative to one's peers, though significant, are small when compared to the adjustments which must be made within the family. When one member of a family unit becomes severely handicapped, the repercussions are felt by each of the family members. Each of the members must learn to accept the disability and learn to adjust to a new life role.

The attitudes of the family towards the client's disability and toward the client as a family member can be powerful assets or liabilities to a successful rehabilitation program. A family group with a healthy supportive attitude toward the rehabilitation program and the client is extremely helpful to rehabilitation success.

It is conducive to rehabilitation to actively include the family members in any comprehensive rehabilitation program. Group information sessions are helpful in educating the entire family as to the nature and extent of the client's disability and what can reasonably be expected of him. Further, family members may be called upon to assist the client not only in the activities of daily living but also in the execution of his daily rehabilitation functions, i.e. physical therapy, occupational therapy, dialysis, administration of medicines, etc. It is extremely important that the counselor evaluate the family's strengths and weaknesses to deliver appropriate services to family members.

Transportation Needs

The severely handicapped client can frequently find himself isolated from the opportunity to engage in vocational pursuits and isolated from medical facilities, shopping areas and restaurants. Many handicapped people are immobilized by their disabilities due to lack of

adequate means of transportation. The severely handicapped client may be limited to public transportation which is often physically difficult for him. To the wheelchair client, boarding a public bus can be an impossible task.

It is basic to the client's complete rehabilitation that he maintain some measure of mobility. The counselor will wish to make an assessment of each individual client's abilities and resources in this area. The counselor can provide, where indicated, such items as taxi coupons and bus passes. However, in the long view, the best solution to the transportation problems of the handicapped is an improved public transportation system.

Public transportation in its present state is a trying ordeal for even the most abled-bodied person. Long waits for public transportation in inclement weather, jostling, pushing, high steps on busses, the need to move quickly to avoid closing doors, attempting to pay a fare and be seated on a moving bus, are all physically difficult tasks for the handicapped. Airports and train travel can also present barriers. The necessity to walk long distances to the terminal gates, the absence of wheelchair ramps in boarding a public vehicle, the absence of elevators, and of course, the ever present hustle-bustle at rush hours impedes the severely handicapped client's mobility.

The United States Department of Transportation in 1968 sponsored a study of public transportation and the handicapped (2). One result of the study was the formulation of guidelines for community planners relative to mass transportation for the handicapped. Local communities should be urged to structure their future transportation facilities taking into consideration the needs of the severely handicapped. It is unlikely that present facilities will be altered to any great degree. But, perhaps any new busses, vehicles, terminals and facilities can have included in their design aids for the severely handicapped.

If we are going to deal with the severely handicapped from a vocational standpoint, mobility is of paramount importance and careful consideration should be given to ways and means of making this mobility possible.

Housing Needs

Every man's home is his castle, but to the severely handicapped individual, his own home can become a hostile, foreboding place in which to live.

Whenever the handicapping condition will permit, the severely handicapped client should continue to maintain his own private domicile. In moving away from the concept of institutional care and towards a life style approximating the norm, it is desirable in most cases for the client to live in private facilities.

Although modification of public and private housing to assist the activities of the handicapped usually costs very little and does not impede the able-bodied, adequate barrier-free housing is difficult to find. In apartment houses such things as wide doorways to accommodate wheelchairs, handrails in hallways and rest rooms, wide elevator doors, placement of elevator buttons within reach of wheelchair clients, elevator signals equipped with raised numerals for the visually impaired, covered entrance ways, and step-free lobbies, would all be aids to the handicapped and would in no way inconvenience the able-bodied.

The interior of a few apartments on the ground floor could be planned to accommodate the needs of the severely handicapped. Accessible placement of electrical outlets, kitchen and laundry equipment, bathroom equipment with handrails and/or weight-supporting towel racks could be included. Private housing constructed with ramps to the entrance way, elimination of steps, use of sliding doors instead of swinging doors, are all aids to the handicapped and are frequently preferred by the able-bodied. In some cases, there are, of course, special needs for each client. In such situations, removal of architectural barriers in the client's home is a must. The client may need to have specialized equipment. For example, the dialysis patient would need special plumbing and electrical wiring to enable him to carry out dialysis within his home.

Those clients whose homes need renovation to remove architectural barriers or who need installation of special equipment should be provided with the necessary items. The rehabilitation counselor and other team members should make a home visit in order to determine what alterations should be made within the client's private home in order to facilitate his activities of daily living and enhance his vocational capabilities. The counselor and client, as part of the team, should participate actively in the decision-making process as well as in the planning for such renovations. Such home improvement items are as essential to some clients as a prosthetic device would be to the amputee.

Efforts should be made to liberalize current legislation in terms of providing Federal home loan funds for remodeling existing homes for handicapped individuals in all areas. The physically handicapped were among the groups in 1968 who were made eligible for mortgage interest subsidies and for some mortgage insurance programs. The hope here is to achieve low interest rates on mortgages for the handicapped.

Summary

To restate, a comprehensive rehabilitation evaluation of the severely handicapped client is inclusive of several facets: medical, psychological, sociocultural, and vocational, as well as housing and transportation needs. The client's past history, present functioning and projected future attainment must be studied in light of these significant factors.

This is merely a suggested model and not to be considered a rigid formula to be applied to each client. Depending on individual need, such things as financial status, legal needs and other dimensions may have to be examined. We must bear in mind the fact that we are dealing with human beings who cannot be dealt with through assembly line techniques.

Each area of study in a comprehensive rehabilitation evaluation must be weighed and considered in conjunction with every other area of assessment. We must take this compilation of data and formulate an overview of the total client. Although each area is undertaken separately, they must all be considered in relation to each other to set forth a complete evaluation of the client's total needs.

While the comprehensive evaluation of the client is being done, the rehabilitation counselor should be noting the family and community resources available for use in any plan of rehabilitation that may be developed. A thorough analysis of available resources should include areas not covered in the evaluation process. The counselor may desire the answer to such questions as:

1. What rehabilitation or medical facilities will be needed to serve this client? Are they available?

2. What are the medical services available to client?

3. What individual and group transportation is available?

4. What service clubs or volunteer agencies might be needed to carry out this specific plan?

5. Are specialized rehabilitation engineering services and equipment needed and available?

6. What special housing is needed? Is it available within the community?

7. What architectural barriers are there in the family home? Can modifications be made or will relocation be necessary?

8. Will either day care or domiciliary care be needed? Is it available?

9. What supportive services and personnel are available to maintain improvement?

10. What is the family profile? What other family members will need to be considered in the development of a plan?

The list of questions above is not a complete list but merely serves as examples of what will need to be taken into consideration in planning for Vocational Rehabilitation services.

A separate area of consideration for the rehabilitation counselor is the financial support necessary for the delivery of services to the client. It is highly unlikely that Vocational Rehabilitation will have all the necessary funds to provide comprehensive services. The rehabilitation counselor will need to explore other sources of funding. In the development of a plan of services for the severely handicapped, the rehabilitation counselor must consider all funding sources including public, private, community, and family. It is doubtful if services can be provided the severely handicapped using only the funds available through state and federally supported programs.

With the abundance of evaluation data available (by the process described above) the counselor is now ready to determine eligibility for service.

PLANNING AND PROVIDING SERVICES

The coordination function of the rehabilitation counselor is of prime importance in the development of a rehabilitation plan. The counselor should be aware, at this point in his case development, of a number of potential agencies that could be involved in the provision of services to his client. Extreme care must be exercised to see that no needed agency or individual is excluded.

The importance of involvement by cooperating individuals and agencies cannot be over-emphasized. If any agency or individual is excluded, the rehabilitation counselor may have to, at a later date, use valuable time in re-establishing good relations and attempting to get cooperation from the excluded individual or agency. It is vital that the counselor report back to all agencies involved concerning the progress of the client. All too often, agencies are called upon for service but not informed of the final outcome. This failure to report back often brings about three problems:

1. Agencies do not share in the success or failure of their efforts.

2. They feel used by Vocational Rehabilitation.

3. They have no means of evaluating their particular input into the program which affects future planning.

Consideration must also be given to client and client's family involvement. They must be involved in the development of the rehabilitation plan, since without their understanding and active support, any plan developed will have diminished chances of success.

Any rehabilitation counselor or agency could prepare a list of services that could be provided for the severely handicapped. Perhaps some counselors would operate more comfortably with such a list but in most cases it would be restrictive and would limit the extent of services that could be used in reaching the objectives of the program.

Each established service objective should be considered separately. The following items are offered to help facilitate questions as they arise.

1. What service is needed to successfully accomplish this objective?

2. Who can provide this service?

3. What will be the cost of this service?

4. What is the time limit of the service and will this particular service extend over the entire time limit?

5. Are there alternative services that would accomplish the same objective?

6. What are their costs?

7. Who can provide the alternative service?

8. Will the provision of this service defer or postpone the accomplishment of other major objectives?

9. If so, what is the hierarchy of services?

A service delivery system devised by answering the above questions must include a decision as to what individual or agency can best provide the service and at what cost.

At this point in the delivery system, the services needed have been outlined, the appropriate person or agency to deliver the service designated, the cost of the service covered, time limits and appraisal methods established. It would appear the rehabilitation counselor could now relax and breathe a sigh of relief. It would be nice if things were that simple. The rehabilitation counselor must expect problems and interruptions of services to arise because of the severity of the handicapping condition.

Use of Volunteers in Providing Services to the Severely Handicapped

Help provided by volunteers is motivated by as many complex forces as there are persons who volunteer to help. One factor which runs through most motiviation, however much its dominance may vary, is idealism. Idealism may mean simply a vivid idea of how things ought to be -- a dream.

For the person needing rehabilitation services the potential value of having his own volunteer is tremendous. The less likely a handicapped person is

able to take up a vocation and become independent and self sustaining, the more some volunteers with truly idealistic motives are stirred to come to his rescue. The relationship can be a good one, if the volunteer is helped to understand the situtation of the handicapped person: what the problem is, what the physical, social and mental prognosis is likely to mean to him, what kind of aspirations he can encourage realistically and what having a volunteer will mean to the person under care. The fact that expectations of change and improvement are low can be a real incentive to volunteers to see what difference they can make in the lives of the persons they touch. The volunteers can take time and demonstrate caring in many ways closed to staff.

Volunteers will need reassurance and help to get involved with severely handicapped persons. Not everyone will be able to do so and compassionate staff leadership enables volunteers to become involved. Personality characteristics are more important than high level skills or education: warmth, a positive attitude, faith and hopefulness are essentials to reinforce the strivings of the person being helped. Such personality characteristics must be somewhat tempered with realistic expectations. The volunteer can learn the high significance of seemingly small evidences of progress and should not build up unattainable hopes either in themselves or the clients.

With the severely handicapped, physical and mental needs are so great that rehabilitation counselors may not have time or resources left for cultural and other esthetic needs. Often volunteers can mobilize resources for the extras which make life more bearable and interesting, even discovering talents and interests which will help the client go beyond self-imposed limitations. Generally if rehabilitation staff pay attention to basic physical, psychological and vocational needs, then the esthetic and spiritual is left out of the client's life. There just isn't time for attention to such "unimportant" things. But time is what the volunteer has to give! He wants to fill his time with worthwhile activity – we must match him to the people who need him most. The esthetic, social or the spiritual may be the special interests of the volunteers.

Volunteers can devise partial care arrangements by day or by night and make the difference between independence and surrender. Meals on wheels, friendly visiting, telephone reassurance, home repair

projects and student-foster grandchildren assignments are a few examples of the sustaining relationships which keep people going on their own. "Adopt a client" project for groups and families make humane experiences and supportive services possible to meet the special needs of the severely handicapped rehabilitation client. The challenges and the satisfactions are great for the volunteers.

Client Role

Counselors are obligated to advise clients that refusal to accept a service will not, in and of itself, preclude the provision of other rehabilitative services. Clients are not inanimate objects and are entitled to and should be encouraged to participate in their rehabilitation planning and programming. Rehabilitation cannot be effective unless attention is given to the clients' emotions and feelings. Client reaction must be given full consideration in light of the severity of the impairment and the accompanying psychological, familial, social, economic, cultural and environmental factors.

The client should demonstrate genuine acceptance and interest in the rehabilitation objective he has helped develop. His role in cooperating with rehabilitation staff will probably need frequent encouragement. Each successful step in working toward the eventual goal of satisfactory employment should help spur the client onward to the next level.

Throughout the rehabilitation process, the client's comments, suggestions and recommendations must be taken into consideration and discussed openly with the counselor and other staff members. The client's right to ventilate feelings regarding the rehabilitation plan is not to be abrogated. Successful rehabilitation is dependent upon client involvement.

Follow-along

The rehabilitation counselor's job cannot be considered finished until a formalized plan of follow-along services has been developed for each client. The counselor should again call upon other state agencies, individuals, local service clubs and volunteer groups to help develop and implement the follow-along plan. The mechanism to assure adequate follow-along should be developed prior to closure. The client and the client's family will need to understand thoroughly the follow-along plan and just what can be expected from this part of the rehabilitation process.

Extreme care must be exercised in the development of the follow-along services to prevent this process itself from creating dependency. While the process should aid the client, it should not prevent him from establishing goals for himself and attempting to carry out other goals.

Consideration, of course, would be given to who can best provide these services and at what cost.

REFERENCES

1. U.S., Department of Health, Education and Welfare, Rehabilitation Services Administration, Statistical Notes, Washington, D. C., July 1971.

2. U.S., Department of Transportation, Travel Barriers, Washington, D. C., 1968.

CHAPTER 3

EXTENDED EVALUATION

Historical Background

Prior to the 1965 amendments to the Vocational Rehabilitation Act, many severely handicapped people were excluded from the Federal/State Vocational Rehabilitation program because it was not possible to determine whether or not they had "rehabilitation potential". State agencies had to determine after an initial diagnostic work up, but before any services were rendered, whether or not a handicapped individual could reasonably be expected to become employable after a program of services was completed.

For many handicapped persons with severe disabilities, this prediction was difficult. As a result, State agencies were unable to provide services to many of these handicapped individuals.

The late Mary E. Switzer, who at the time was Commissioner of Vocational Rehabilitation, testified at hearings of the United States Senate Subcommittee on Health of the Committee on Labor and Public Welfare concerning the proposed 1965 amendments to the Vocational Rehabilitation Act. Miss Switzer outlined the difficulty in providing Vocational Rehabilitation services to severely handicapped individuals caused by the necessity to determine and certify probable rehabilitation potential before any services other than initial diagnostic work ups could be rendered. She said:

> "We propose an amendment to the act for a program of formula grants to States to enable the State agencies to work with many severely disabled who now cannot be accepted for services.
>
> "As the present law operates, a State agency cannot begin a plan of services to a disabled person unless the agency can first determine that the individual has reasonable prospects for employment when services are completed. We propose that the law be revised to encourage the State agencies to accept disabled persons where the vocational potential is not clear, provide services for a limited period of time, observe the response to services, and then decide whether or not the person can become employable.

"Our experience has shown that this amendment is necessary if we are to make full use of the vocational rehabilitation program in this country.... we are dealing with increasing numbers of severely disabled people, many of whom have been out of the labor market for long periods of time or have never had a job. This means that the task of predicting employability in advance becomes extremely difficult. At the same time, we know from our research and demonstration programs and from the experience of the State agencies with special projects, that a substantial number of these long-time unemployed and severely disabled people can be returned to employment with the provision of vocational rehabilitation services....." (5).

Testifying before the same committee, Howard A. Rusk, professor and chairman of the Department of Physical Medicine and Rehabilitation, New York University Medical Center, said:

".....As a physician I know quite well the difficulty of making early predictions about what a disabled person can or can't do. I have told audiences all over this country that there is one maxim in rehabilitation which must never be violated: Never tell a disabled person he cannot do something without first giving him a chance to do it.

"Yet under our present Federal law, we are asking the rehabilitation counselor in the State agency to make an initial prognosis about a disabled person which nobody should be asked to make. He is expected, after initial diagnostic work up, to decide whether or not the person will be able to get and hold a job at some time in the future when the rehabilitation program has been completed. For literally thousands of disabled people, who are the victims of serious disabilities plus many associated difficulties, it is simply impossible to make this kind of prediction at that very early stage. Because of this, large numbers of severely disabled people who might be helped must be turned away by the State vocational rehabilitation agencies before they even begin a program of rehabilitation services....." (5).

The extended evaluation provisions became part of the 1965 amendments to the Vocational Rehabilitation Act which were effective July 1, 1966. The Federal provisions for this extended evaluation are outlined in Chapter 16, Section 1 of the Vocational Rehabilitation

Manual which states, "The amended law makes it possible for State agencies to provide vocational rehabilitation services to handicapped individuals before a determination has been made that there is a reasonable expectation that vocational rehabilitation services can fit him for employment. The major purpose of providing such services is to evaluate their effect on the individual, thus facilitating making a determination that there is or is not a reasonable expectation that vocational rehabilitation services will render the individual fit to engage in a gainful occupation (the third condition of eligibility)..." (9).

In order to place a prospective client in a program of extended evaluation to determine his rehabilitation potential, a State Vocational Rehabilitation Agency must show that the following three conditions exist:

a. The presence of a physical or mental disability.

b. The existence of a substantial handicap to employment.

c. An inability to make a determination as to the third condition of eligibility (that there is a reasonable expectation that Vocational Rehabilitation services will render the individual fit to engage in a gainful occupation).

Extended evaluation, including the provision of Vocational Rehabilitation services, may be provided for a period of up to 18 months if necessary in order to determine the rehabilitation potential of individuals whose disability is 1) mental retardation, 2) deafness, 3) blindness, 4) paraplegia, quadraplegia, and other spinal cord injuries or diseases, 5) heart disease, 6) cancer, 7) stroke, 8) epilepsy, 9) mental illness, 10) cerebral palsy, 11) brain damage, 12) arthritis, 13) muscular dystrophy, 14) cystic fibrosis, or 15) renal failure; and up to 6 months for individuals with other disabilities.

A wide variety of Vocational Rehabilitation services is available through extended evaluation. Occupational tools, equipment, initial stocks and supplies, management services, supervision for vending stands and other small business enterprises, and occupational licenses if necessary to determine the vocational rehabilitation potential of an applicant are examples of services available

under extended evaluation. Further details of Federal requirements and regulations concerning extended evaluation of rehabilitation potential can be found in Chapter 16 of the Vocational Rehabilitation Manual and Section 401.31-33 of the Regulations (9,3).

Extended evaluation would appear to be a major step forward in providing Vocational Rehabilitation services to severely handicapped people. Of the 9,000 clients who received extended evaluation case services in Fiscal Year 1968, 58% were not accepted for regular Vocational Rehabilitation services (8). Thirty-six percent were closed rehabilitated, while the remaining 6 percent were closed not rehabilitated. What is of particular significance, 3,780 people were accepted for regular Vocational Rehabilitation services after being provided with services under extended evaluation.

During Fiscal Year 1971 State Vocational Rehabilitation Agencies placed 25,570 clients in extended evaluation services. Over 13,700 clients given extended evaluation were processed into the active caseload while just over 10,000 were closed from extended evaluation as not eligible for regular Vocational Rehabilitation services due to their lack of feasibility. During the three year period beginning July 1, 1968 and ending June 30, 1971, some 112,828 extended evaluation cases were identified; 37,090 or 32.7% of these were certified for Vocational Rehabilitation services (6). Moving on to Fiscal Year 1972 data, the following table presents a breakdown of the cases processed through extended evaluation.

FISCAL YEAR 1972

		%
Processed during year	26,024	100
Certified for VR		
6 months	4,323	17
18 months	10,545	40
Closed, not certified		
6 months	3,566	14
18 months	7,590	29
Remaining on June 30	20,422	

As the above data suggest extended evaluation has made it possible to provide rehabilitation services to thousands of severely handicapped

people who formerly might have been declared ineligible after an initial diagnostic work up.

Importance

The importance of careful evaluation has been reemphasized as a result of Congressional interest in extending the program to handicapped persons even though their vocational potential is uncertain. This fact is demonstrated by the Senate report (4) on Vocational Rehabilitation legislation emphasizing the need to utilize effectively extended evaluation. These statements in the report are particularly significant:

> "The basic purpose of the Committee bill is to continue and expand rehabilitation services to handicapped individuals by providing an expansion of authorization and changes in legislative authority designed to ensure full services to handicapped individuals and better enable this program to serve individuals with more severe handicaps.....
>
> "The Committee bill, in recognition that a productive life is of primary importance, also attempts to insure that no individual may be excluded from vocational training, counseling and related services aimed at a vocational goal without thorough and detailed evaluation of his rehabilitation potential and an explicit statement by the rehabilitation counselor encompassing the reasons why he has concluded beyond a reasonable doubt that a vocational goal is not appropriate."

Attention is directed to certain key words in the previous paragraph: "thorough and detailed evaluation of his rehabilitation potential." Although evaluation has always been an important service in rehabilitation, it assumes even greater importance when working with the severely handicapped. The Full Study Group of the Institute on Rehabilitation Services believes that in most cases extended evaluation will be necessary to determine the kinds of services needed to help the severely handicapped person achieve his potential.

It was apparent to the Full Study Group of the Institute on Rehabilitation Services that extended evaluation has not been utilized as extensively as the law originally intended. Some possible reasons for the underutilization of extended evaluation may be worthy of mention:

1. Extended evaluation presumes the expenditure of Section 2 funds, a fund source usually exhausted before the fiscal year ends. In most states, Section 2 monies have been diverted to many target populations and the priority given to extended evaluation services was negligible.

2. If a client in extended evaluation secures employment, administrative regulations preclude the counselor from recording a 26 closure unless the counselor chooses to accept the case, write a plan and implement services. Therefore, the rehabilitation counselor may be more inclined to be lenient in applying the "reasonable expectation" test for eligibility for Vocational Rehabilitation services.

Components in Extended Evaluation

In a program concerned with extended evaluation and with services for the severely handicapped, it is important that careful attention be given to the ability of the individual to function in his present community environment. Careful assessment should be made of his ability to respond to the required capacities for the performance of basic roles and activities. Each of the areas of human activity mentioned earlier can be evaluated in terms of the degree of ability-inability.

Hanman (2) says,"The need is for an evaluation of the total physical and emotional assets of the whole person for activities around the clock—not only for the activities of working, as is often done, but also for the duties of daily living. Regardless of diagnosis or status in life, the basic question remains the same for each person in turn: Depending on his own unique balance of fitness and unfitness for human activity, how can he utilize his physical abilities to get the most out of life without hurting himself?"

Careful consideration should also be given to a determination of vocational potential, that is, the work status a client may be capable of reaching after he receives extended evaluation services. There are many technical methods for the measurement of work readiness. Competent evaluation must include careful medical examination and accurate measurement of functional capacity. One workable classification may be outlined as follows:

1. endurance: the ability to perform continuously, physical tasks over a given period of time
2. strength: the ability to overcome mechanical resistance without help
3. mobility: the ability to walk without assistance, climb stairs, etc.
4. dexterity: the ability to coordinate and manipulate body members
5. expression: the ability to communicate through speech or writing
6. sensory-perception: the ability to taste, touch, hear, smell and see
7. intelligence: the ability to mentally identify and evaluate information collected by the senses
8. resistance: the individual's capacity to overcome damage from illnesses or injuries or traumatic social experiences
9. motivation: determination to improve one's performance

In 1956, the American Medical Association created the Committee on Rating of Mental and Physical Impairment. The revised guides (1) developed by the Committee provide a practical system for the evaluation of permanent impairment. The numberical values used in the guides provide quantitative measurement and avoid the use of general terms such as "slight", "marked", and

"moderate". Medical signs, symptoms, and laboratory findings provide useful kinds of information but are not a substitute for a clear and concise summary of functional limitations. Use of the guides by physicians will provide the rehabilitation counselor with complete medical information and an objective measurement of function. Counselors should become familiar with the guides and encourage physicians to use them.

Costs for Diagnosis and Evaluation

The State Vocational Rehabilitation Agencies make periodic reports to the Rehabilitation Services Administration concerning costs for case services. The following data on costs for diagnostic and evaluation services for the past six years is interesting and informative. (7)

Service	Fiscal Year	Cost	Percent of Case Service Expenditures	Average Cost Per Client
Diagnosis and Evaluation	1967	$14,570,000	9.2	$35.00
Diagnosis and Evaluation	1968	$31,953,000	16.4	$64.00
Diagnosis and Evaluation	1969	$36,678,000	16.0	$68.00
Diagnosis and Evaluation	1970	$41,924,000	15.5	$72.00
Diagnosis and Evaluation	1971	$55,341,000	15.7	$82.00
Diagnosis and Evaluation	1972	$60,142,000	15.1	$82.00

Instructions to the State Rehabilitation Agencies in Chapter 12, Section 1 of the Vocational Rehabilitation Manual (9) as to costs to be assigned to diagnosis and evaluation services are as follows:

"Include in these accounts the cost of diagnostic and evaluative services or procedures including the necessary cost of transporting clients in connection with such services and the cost of hospitalization for such purposes. Diagnostic and evaluative services may be obtained from rehabilitation facilities, or other sources. Medical, psychological, social and vocational diagnostic and evaluative procedures are also included when authorized for the purpose of determining the client's eligibility or to throw light on the nature and scope of vocational rehabilitation services needed in a period of extended evaluation to determine the client's rehabilitation potential or those needed after eligibility has been determined. Diagnostic and evaluative services may be provided at any stage of the rehabilitation process, if they are required for a more thorough understanding of the client's capacities and limitations. They are not restricted to an initial medical examination or psychiatric or psychological evaluation or to the early stages of the case."

Role of the Rehabilitation Counselor

The rehabilitation counselor, as he endeavors to serve substantial numbers of the severely handicapped, will frequently be faced with this important question: If a vocational goal is not apparent, are there services which, if provided to the severely handicapped, would permit the individual to improve his ability and enhance his vocational potential? It is the rehabilitation counselor who must decide whether the individual is severely handicapped and could benefit from extended evaluation services. He must carefully weigh the medical information and other kinds of assessment data in making this determination.

The Full Study Group of the Institute on Rehabilitation Services feels that extended evaluation, if properly funded through a formula funding grant, can indeed be the vehicle which would increase Vocational Rehabilitation services to a greater number of severely handicapped individuals.

REFERENCES

1. American Medical Association, Guides to the Evaluation of Permanent Impairment, Chicago: American Medical Association, 1971.

2. Hanman, Bert, "The Evaluation of Physical Ability", New England Journal of Medicine, May 15, 1958.

3. U.S. Federal Register, Vol. 34, No. 200, Friday, October 17, 1969, Part II, Department of Health, Education and Welfare, Social and Rehabilitation Service, Vocational Rehabilitation Programs and Activities, Section 401.31-34.

4. U.S., Congress, Senate, Report No. 93-48 to accompany S-7 Rehabilitation Act of 1972, Washington, D. C., February 26, 1973.

5. U.S., Congress, Senate, Committee on Labor and Public Welfare, Subcommittee on Health, To Amend the Vocational Rehabilitation Act, Hearings 89th Congress, 1st Session, on S. 1525, March 29 and 30, 1965.

6. U.S., Department of Health, Education and Welfare, Rehabilitation Services Administration, Caseload Statistics – State Vocational Rehabilitation Agencies, Annual Reports for Fiscal Years 1968 through 1972.

7. U.S., Department of Health, Education and Welfare, Rehabilitation Services Administration, Program Data – State Vocational Rehabilitation Agency, Annual Reports for Fiscal Years 1967 through 1972.

8. U.S., Department of Health, Education and Welfare, Rehabilitation Services Administration, Statistical Notes, Washington, D. C., July 1971.

9. U.S., Department of Health, Education and Welfare, Rehabilitation Services Administration, Vocational Rehabilitation Manual, Washington, D. C., 1970.

CHAPTER 4

CONSIDERATIONS IN MEASUREMENT

In order to evaluate adequately the impact of rehabilitation services on the client, a minimum of three types of measures should be available to the program evaluator. These are: (1) an index of case difficulty; (2) an index of client change and client functioning and (3) a closure status.

Case Difficulty

Measures of case difficulty are needed in order to see whether rehabilitation is, in fact, meeting its goal of serving the handicapped. Essentially case difficulty deals with: (1) the intrinsic limiting factors present in the client; and (2) resources available to overcome these limitations. Case difficulty would refer to the limitations imposed on the client by his disability and his reaction to the disability. Case difficulty might be seen as what the client presents to Vocational Rehabilitation. The other aspect of case difficulty concerns the resources the Vocational Rehabilitation program can employ in attempting to alleviate the client's problem. This second aspect concerns things such as availability of facilities, the money available to the counselor, and the counselor's skill and effort in providing services.

Client Change

Measure of client change refers to the status of the client in relationship to medical, psychological, sociocultural and vocational factors at any given period of time. The measure is called client change, rather than progress, to leave open the possibility of negative change or deterioration. This measure is related to the client's starting point and is measurable at any time after the original measurement of the client's status.

Closure Status

Closure status would indicate the client's status in relation to his environment and the world of work. Closure information would isolate the extent of adjustment made by the client in the perspective of the outside world.

LEVELS OF CLIENT FUNCTIONING

Productive Life Activities Successful gainful activity or gainful work
Purposeful Life Activities Restricted Workshop Employment Activity Centers Complete Self-Care and Self-Reliance
Marginal Life Activities No Employment Supported Self-Care Day Care Center Activities Mobility
Confined Life Activities Homebound Domiciliary Care Special Living Arrangements Increased Self-Care & Mobility In Home & Neighborhood
Life Sustaining Activities Difficulty in - Communications Ambulation Manipulation And Self-Care (Toilet, Grooming, Feeding, Etc.) Protective Services
Life Threat Stage Complete Incapacity Substantial Improvement Potential Not Present

A system of closure statuses would include breakdowns similar to, although more refined than, the traditional closure system. Categories could be defined in terms of work status, weekly earnings, vocational level, client's financial independence, etc. The categories of closure status could then be the base for determining the costs of rehabilitation.

In essence, these three measure (case difficulty, client change, closure status) are not measuring totally different types of things, but are viewing the effect of rehabilitation services upon three different aspects of the program, each of which is important to the goals of rehabilitation. To eliminate any of these three aspects would not only result in the loss of valuable information, but also - when implemented - would distort the actual operation of the system by placing undue emphasis on some aspect at the expense of the others. If measures of this sort are devised and implemented, the programs will be able to be evaluated more adequately and, therefore, place better information in the hands of program planners.

MEASUREMENT SYSTEM

A suggested format to measure levels of client functioning, client change, and casework difficulty is provided for review and deliberation.

The format is a systems approach to measuring severity of handicap, periodic determination of individual levels of client performance, and an actuarial or predictive mechanism for providing an index of casework difficulty.

Client Functioning and Severity of Disability

One way to establish whether or not "substantial improvement" has occurred is to establish a hierarchy of activity levels. Then, by comparing the client's functioning to the levels of activity, it would be possible to make an accurate appraisal of substantial improvement. If the client has been able to move upwards on the hierarchy, there has been substantial improvement. Or if the client has been maintained at the same level and further deterioration has been prevented, this would be important to note.

A suggested hierarchy follows: Level One: successful, gainful activity and/or gainful employment; Level Two: capable of all self-care and

household tasks, can travel independently, pursues social and recreational interests, is capable of marginal types of employment; Level Three: capable of all personal care and some household duties, is somewhat mobile but not completely independent in terms of traveling alone (shopping activities, medical appointments, etc.); Level Four: capable of important required personal care activities, can do some household activities, is basically homebound; Level Five: individual can carry out little or no self-care, needs constant personal attendant or institutionalization; Level Six: complete incapacity, terminal illness.

Client Change

Once the levels of client functioning have been determined, the counselor would be expected to indicate and record changes made in the client's levels of functioning resulting from the provision of Vocational Rehabilitation services.

If a rating scale is constructed which addresses itself to the appropriate problems of the severely handicapped and to five of the six hierarchial levels, it could reflect the changes effected by the program. It could portray the client's strengths and weaknesses, and indicate areas in which additional resources need to be erected. By using this model in Vocational Rehabilitation, it is possible to measure client change or movement, and at the same time given an index of the client's present status whenever the instrument is applied.

Form A makes use of such a method (See Appendix C). The information can be put in quantified terms, and a 'mean' performance level established. This approach to determine client change could be called a Functional Model Movement Scale. The form can be used as an assessment tool to assist in the counselor decision-making process to establish eligibility for rehabilitation services. It may also be administered periodically to measure client gain.

The rehabilitation counselor's work affects many areas of the client's total life. These areas might be categorized as physical, educational, vocational, economic, and psychosocial. Utilizing Form A or a similar breakdown, a client's strengths and weaknesses in terms of functioning could be established.

In the physical area, questions could be asked about the client's general tolerance, the time he could be involved in physical activity and the type of activity. Does the client have any compensatory skills and if so, to what degree does this help compensate for his disability? Does he have secondary or multiple disabilities to cope with? What is the client's general health status other than the disability? The following are examples from Form A covering physical functioning:

IV.

D. Work Tolerance

_____ 1. Minimal restrictions to type of work client can do
_____ 2. Occupations limited to light physical activity but able to work full-time
_____ 3. Sedentary work, low stress, or close supervision required; but able to work full-time
_____ 4. Unable to work full-time because of mental or physical condition
_____ 5. Current disability status precludes employment

F. Compensatory Skills

_____ 1. Has developed in other skill areas or with the use of devices, almost total compensation for disability
_____ 2. Has significant development in other skill areas, or with the use of devices, abilities which help compensate for disability
_____ 3. No real development in other skill areas and minimal use of devices
_____ 4. Some deterioration in other skill areas
_____ 5. Substantial deterioration in other skill areas

Educational background – how much? what type? The client's learning ability and skill level attained are important questions. Form A includes:

II. EDUCATION

A. _____ 13 years and above
B. _____ 10 - 12 years
C. _____ 7 - 9 years
D. _____ 0 - 6 years
E. _____ Special Education

VI.

A. Language Facility

_____ 1. Reads and writes well; has no trouble understanding and communicating common vernacular and could learn to use technical language

_____ 2. Reads, speaks, and writes adequately; has no particular problem filling out employment applications, or holding job interview

_____ 3. Reads, speaks, and writes adequately for job applications and interview, but speaks slowly and may have some difficulty with other than simple written instructions

_____ 4. Reads, speaks and/or writes poorly, and will have difficulty interpreting even simple written instructions

_____ 5. Almost complete lack of language, functionally illiterate, extremely small vocabulary

The client's past education may offer clues to his interests and abilities and indicate under-developed skills which may be sharpened, allowing the client to live with a greater degree of independence and self-sufficiency.

The vocational and economic areas would address themselves to the client's dependence on others for financial support, source of support or pressing financial problems that might lead the client to terminate services early and, thereby, not reach his optimal functioning level, such as:

III.

E. Dependency of Client on Others for Financial Support

_____ 1. Completely independent

_____ 2. Approximately 25% of income comes from sources other than earnings

_____ 3. Approximately 50% of income comes from sources other than earnings

_____ 4. Approximately 75% of income comes from sources other than earnings

_____ 5. Totally dependent on sources other than earnings

The phychosocial area may be the most subjective, but information is needed in reference to interpersonal skills or other social skills. How does the client respond to others attempting to aid him? Are his

expectations realistic? Is the client able to make decisions and implement plans for attaining future goals? Is his family supportive, or do they misunderstand his illness and present an obstacle to the client's rehabilitation? Examples from Form A are:

V.

B. Compatibility of Employment Expectations with Client's Personality and Physical Condition

_____ 1. Client seems ideally suited for the work he desires
_____ 2. Client's employment expectations are reasonable, although not ideal
_____ 3. Client has no ideas concerning possible vocational goals, or his ideas are more "day dreams" than employment expectations
_____ 4. Client's employment expectations are very unrealistic and impractical
_____ 5. Client's employment expectations are so totally unrealistic and impractical, counselor must work with other professional persons, agencies, or institutions before client can proceed in the rehabilitation process

VI.

D. Family Support

_____ 1. Good; family shows great deal of understanding of client; very supportive and helpful
_____ 2. Moderate; although not ideal, support is adequate
_____ 3. Fair; support given but is inappropriate; evidence of underlying ambivalence on the part of the family
_____ 4. Poor; support given but there is definite indifference on the part of the family toward client or his rehabilitation
_____ 5. Very poor; family definitely non-supportive, strong opposition

These are the types of questions a model concerned with functional capacity asks in rating difficulty or movement. These are not factors unrelated to the medical and psychiatric models, but they concern themselves directly with the work of Vocational Rehabilitation.

Actuarial Approach to Measurement and Casework Difficulty

Why Actuarial? You may already have heard the term "actuarial". Probably in the context of life insurance. Actuarial tables are devices for computing things like life expectancies.

What does actuarial have to do with measuring program functioning? What does it have to do with the severely disabled?

To answer these questions, another has to be asked. What's the difference between someone who is severely disabled and one who isn't?

It's harder to rehabilitate the one who is severely disabled.

But, what does "harder to rehabilitate" mean? It means you don't EXPECT rehabilitation to be as likely.

Let's come at the same thing but from a different angle: the feasibility test for provision of Vocational Rehabilitation services. What does that mean? It means there is a reasonable EXPECTATION that – given the provision of services – rehabilitation will be achieved. Again, expectation.

No matter how you slice it, the feasibility test is radically an actuarial type of thing.

If you just substitute the word rehabilitation for insurance, you can see that the decision of give vs. deny insurance is similar to the Status 10 plan development and determination of eligibility vs. Status 08 closed from referral choice a counselor has to make.

Examples. Some actuarial approaches to program measurement have already been initiated. Sermon's studies in the Minnesota Agency are one example. (1) Here, caseload difficulty is weighted according to disability. The weights are derived from the comparative profile of successful vs. unsuccessful clients. Sermon has taken these data and converted them into an expectancy table.

For example, data show that the expectation of rehabilitating a drug addict is – everything else being equal – a lot less than rehabilitating someone whose primary disability is dental. So Sermon's index would give appropriate weight to their differential expectation.

Sermon's work (and other like it) is a good start. A nice thing about it is that it is drawn from routinely available R-300 of State Agency information. A drawback to this approach is that the expectancy table and resultant weights are based on only one factor—primary disability.

The insurance expectancy tables are based on more than one factor. So, too, research conducted at several sites (e.g., West Virginia Research and Training Center) indicate that the R-300 itself has a lot more actuarial potential.

The following factors have been identified as significantly related to expectancy of rehabilitation or—if you prefer—severity of handicap:

1. Referral source
2. Sex
3. Age
4. Marital status
5. Dependents
6. Education
7. Work status at entry
8. Source of support

It should be pointed out that all of the above list are R-300 information and routinely collected by State Agency. The information is available at the point of client application or referral—in other words, pretty early in the ballgame.

Computer programs can be made available that can take these eight factors and combine them so as to yield a composite severity index that is of higher accuracy than using just disability.

Potential Use

1. Incentive Value. With increasing emphasis in serving the severely disabled, the counselor is in a bind. The most commonly used accountability criteria is a raw number of successful rehabilitation closures. The problem here is that a successful rehabilitation closure counts the same whether client was a paraplegic or a hernia repair. The raw number accountability test actually provides negative incentive to serving the severely disabled. Why? Because a closure is still chalked up a 1 whether it's a client who is severely disabled or one who is only mildly disabled. To be sure, the professionalism of the counselor and supervisory sense of integrity exert corrective forces on this.

But the thing to keep in mind is that both supervisory integrity and counselor professionalism are informal influences against the singular "official" criteria of raw number of closure production. An actuarially-based weighting scheme creates a formalized incentive for working with the severely disabled. It gives management an equitable, impartial incentive for working with the more severely disabled.

2. Program Evaluation Implications. Any attempt to measure rehabilitation effectiveness is hampered if it does not take into account expectancy of rehabilitation.

   Example: Two cord-injured centers A and B are in operation in a state. Both produce 100 successful rehabilitants a year. (And let's assume that both have exactly the same proportions by disability code.) But facility A does it for a per closure cost of (say) $10,000. Facility B does it at a per closure cost of $15,000. Is facility B less efficient than A? That question is totally unanswerable unless you have some weights for the difficulty of closures at the respective facilities.

   We're not saying that weights are a sufficient pre-condition for precise program evaluation. But they are a necessary pre-condition for same.

3. Program Drift. With an actuarial measurement system, it's possible to monitor program drift. For example, does the rehabilitation program in fact produce more severely disabled in response to revised priorities. Unless rehabilitation managers have some operationally-based index of severity, such monitoring of program drift is elusive – if not illusory.

4. Lessening Political Vulnerability. If programs move to deal with the more severely disabled, a reduction in successful rehabilitation closures is not out of the question. Rehabilitation administrators would then be vulnerable to criticism from legislators and other political representatives because it would appear that efficiency was decreasing. An actuarially-based measurement scheme would lessen the vulnerability of administrators by providing an objective basis for justifying decreases in raw numbers by increases in severity of cases served.

Problems

1. Attitudinal Resistance. Rehabilitation is a humanitarian enterprise. Implementing an actuarial measurement system with its seeming reduction of a person to a cold impersonal fly speck on an expectancy table – all this might not grab rehabilitation people just right.

2. Technological Resistance. Right now rehabilitation agencies use computers mostly to generate routine fiscal and administrative types of output. To develop the kind of actuarial system we are discussing here requires the availability of novel software. Such software is routinely available at most computer centers. But the problem is how to establish appropriate liaison with such centers. The initiative for such contact will have to come from the agency.

Getting Down to Particulars

A. Background

To illustrate how an actuarial system works in practice, we'll go through an example. This example is taken from R-300 data derived from one State Agency.

An analysis of these data showed that eight factors present at referral had a statistically significant bearing on ultimate rehabilitation rate. Example, referral source.

1. Referral Source

Referral Source	Rehabilitation Rate
Self; Other Individuals	
Physicians	50%
Mental or Correctional Institutions	7%
Other	27%

This chart indicates that 50% of those who were self-referred (etc.) wound up rehabilitated; but only 7% of those from mental or correctional institutions.

2. Sex

Sex	Rehabilitation Rate
Males	27%
Females	43%

Twenty-seven percent (27%) of the males wound up rehabilitated versus 43% of the females.

3. Age

Age	Rehabilitation Rate
35 or older	42%
Under 35	21%

4. Marital Status

Status	Rehabilitation Rate
Married	40%
Never Married	16%

5. Dependents

Dependents	Rehabilitation Rate
One or more	40%
None	29%

6. Education

Education	Rehabilitation Rate
8 or more	39%
Less than 8	30%

7. Work Status at Entry

Status	Rehabilitation Rate
Employed	65%
Unemployed	23%

8. Source of Support

Source	Rehabilitation Rate
Self	65%
Family	33%
Public Assistance	22%

B. Rehabilitation Success Profile (RSP)

With the eight factors listed above, plus disability category, it's possible to develop at acceptance (or at referral) a Rehabilitation Success Profile (RSP) for each client.

The RSP looks like this.

REHABILITATION SUCCESS PROFILE

FACTOR	REHABILITATION RATE
Referral	7
Sex	27
Age	21
Marital Status	16
Dependents	29
Education	30
Work Status	23
Source of Support	22
Disability	66
Rehabilitation Success Index	241

What you see is the profile for a male, under 35 referral by a mental institution. He has never been married, has no dependents and less than 8 years of education. He is unemployed, on public assistance, and his primary disability is a psychotic disorder.

Contrast this case with a self-referral female, over 35, who is married with one dependent and more than 8 years of education. She is self-supporting through employment and her primary disability is dental.

REHABILITATION SUCCESS PROFILE

FACTOR	REHABILITATION RATE
Referral	50
Sex	43
Age	42
Marital Status	40
Dependents	40
Education	39
Work Status	65
Source of Support	65
Disability	92
Rehabilitation Success Index	476

By adding the rehabilitation rates for each of the 9 factors, it's possible to derive a composite Rehabilitation Success Index (RSI).

As you can see, the first client has an RSI of 241, while the second has a much larger score of 476, thus providing numerical documentation that the first client was more severely handicapped than the second.

The higher the number, the greater the chances of rehabilitation. The lower the number, the harder the case. The maximum index score would be 476.

C. Advantages

The advantages to this system are:

1. It's objective, not a piece of guesswork.

2. It combines and weights a number of relevant factors rather than just disability.

3. It's easy to develop. The charts for factors one through eight can be easily developed by a state agency. The chart for factor nine can be developed from Rehabilitation Services Administration statistical reports. Computers are not necessary.

4. It's easy to use. Once the charts are developed, the RSI is a matter of consulting the table, writing down nine numbers and adding.

5. An RSI can be computed on a client even in the absence of a face-to-face interview. This makes it a very flexible method of assessing severity of handicaps.

6. It's economical. It requires only a few minutes of time and doesn't require collecting any information other than that routinely obtained from the R-300 which all State Agencies collect.

D. Further Uses

In addition to assessing severity of handicaps on a case-by-case basis, it's possible to average RSI's by state, by districts within a state, by counselor within a district, etc.

E. Cautions

1. The RSI provides a device for rank ordering case difficulty. In other words, an RSI of 400 indicates less severity of handicaps than an RSI of 200. It does not mean that the 400 client is twice as easy as the 200 client.

2. When using the RSI approach for comparison purposes (e.g., from district to district within a single state) other factors

need to be kept in mind. For example, differing employment conditions might have a significant impact on ease of rehabilitation across-the-board. Everything else being equal, if you're disabled in an area of high unemployment, chances of getting a job are less than in a low unemployment area. Also differential availability of rehabilitation facilities and resources can have a similar across-the-board effect.

In summary then, use the RSI for comparative purposes only if other prevailing factors are equivalent. To the extent such equivalency is not present, the interpretation of the RSI type comparison needs to be correspondingly adjusted.

3. The RSI approach described above is simple but has some methodological limitations not present with more elaborate techniques (e.g., multiple regression analysis). But the RSI is a good place to start if you're interested in developing a basic tool to define severity of handicap. As rehabilitation researchers dig into this area, improved RSI models can be expected.

Client/Case Performance and Evaluation

The two systems discussed above measuring (1) client change and levels of functioning and (2) casework difficulty provide a base from which Vocational Rehabilitation programs can establish criteria for performance patterns and evaluation activities. With further refinement one can establish appropriate and more objective goal-setting for individuals to be served.

If the two systems of measurement are developed in a comprehensive manner, we may find that they also become tools by which a counselor can objectively screen out the severely handicapped client. Using a measurement system such as the one outlined in this Chapter, we may find that a client is referred to a Vocational Rehabilitation agency with the following known factors:

The client is functioning at level 5 with difficulty experienced in life sustaining activities of communication, ambulation, manipulation and self-care. Indices developed by actuarial data reveal the client has an

unfavorable or difficult set of factors to overcome. She has been referred by a welfare agency, age 44, never married, two dependent daughters, each have one illegitimate child, sixth grade education, infrequent work as a fruit picker, and has derived her source of support during the last ten years from welfare aid.

Taking all factors into consideration a counselor may find, with a sophisticated measurement system, that the above client has all the factors necessary to be considered severely disabled and severely handicapped.

The measurement system may also equate the rehabilitation of this client to fifty clients having less severe disabilities or handicaps. The measurement system might also reveal that client change in the example case would be slow and may never reach the objective of competitive or gainful work. A comprehensive measurement system may in fact generate more activity in screening out the severely disabled and handicapped from Vocational Rehabilitation services than has previously existed.

These measurement tools may be used by agency administrators and counselors to justify not serving the severely disabled and handicapped. Fortunately or otherwise the Vocational Rehabilitation program may be faced with a dilemma of whether to serve the severely disabled for humanitarian reasons or to serve those severely disabled who through objective measurement techniques exhibit those factors which contribute to successful Vocational Rehabilitation.

However, if a Vocational Rehabilitation agency is serious about providing services to the severely disabled, a measurement scheme such as the one presented above can provide administrators with a concrete monitoring device that allows for checking whether or not agency intent is being reduced to reality.

Other Uses Derived From a Comprehensive Measurement System

The measures described in this Chapter may also be used by Disability Determination Examiners as a mechanism for screening Disability Insurance beneficiaries and Supplemental Security Income recipients for referral to the Vocational Rehabilitation agency.

Administrators of Disability Examiners programs may wish to analyze case profiles to determine the nature and extent of "severely handicapped" individuals receiving monetary benefits.

REFERENCES

1. Sermon, Duane T., The Difficulty Index – An Expanded Measure of Counselor Performance. Monograph No. 1, Division of Vocational Rehabilitation, State of Minnesota, St. Paul, Minnesota, March 1972.

APPENDIX A

LEGISLATIVE HISTORY RELEVANT TO SEVERELY DISABLED

Throughout the history of the Federal/State Vocational Rehabilitation program, there has been significant legislative development relating to the severely disabled. Each succeeding piece of legislation made possible some advance in terms of the ability of the program to provide services to people with more serious handicaps.

Legislation is cited below that has had the most significance in terms of the severely disabled and indicates the trend toward providing more services to this population.

1920. The Smith-Fess Act (The National Civilian Vocational Rehabilitation Act) marked the beginning of the Federal/State Vocational Rehabilitation program. The ability of the program to provide meaningful services to the severely disabled was somewhat limited. Public Law 66-236 provided for services to the physically handicapped; people with mental disabilities were not included. The funding level was a modest $1,000,000 to be matched by States at a 50 - 50% ratio. The expenditure of funds was limited to vocational training, counseling, prostheses, and placement services. During the period 1920 - 1943, there were no changes in the kinds of services which could be provided.

1936. The Randolph-Sheppard Act authorized the states to license qualified blind persons to operate vending stands in federal buildings or federally sponsored buildings. This has been expanded to include non-federal buildings. During Fiscal Year 1972, 3,229 vending stands provided employment for 3,583 operators under this program.

1943. When it became law on July 6, 1943, Public Law 78-113 superseded the act of 1920 (as amended up through 1942) and authorized major amendments to broaden the Vocational Rehabilitation program. The law, frequently referred to

as the Barden-LaFollete Act, had a substantial impact on the program in terms of authorized services and clients eligible for rehabilitation. For the first time, services were extended to the mentally handicapped and to the mentally ill.

The legislation provided that clients could be furnished any services necessary to prepare them for employment. For the first time, funds were made available to provide clients with medical, surgical and other physical restoration services required to eradicate or alleviate their disabilities. The authorized services included surgery and therapeutic treatment, hospitalization, transportation, occupational licenses, tools and equipment, prosthetic devices, and maintenance during training.

Under this law, the separate State Agencies established to serve the blind first came into the Federal/State Vocational Rehabilitation program. At the present time there are 28 separate blind agencies providing services to the blind and the visually handicapped.

1954. The Vocational Rehabilitation Amendments of 1954 (Public Law 565) were far reaching in their impact on the provision of rehabilitation services to the handicapped. The law provided for training grants in support of educational programs for professional rehabilitation personnel, including trainee scholarships and stipends. A new system of extension and improvement project grants provided funding to states to develop new aspects of their programs and to extend their services to disability groups and geographical areas previously reached inadequately or not at all. The new law also authorized for the first time the use of federal grants to states for establishment, alteration or expansion of rehabilitation facilities and workshops, many of which provide services and employment to the severely disabled.

1965. The Vocational Rehabilitation Act Amendments of 1965 (Public Law 333) were noteworthy for a number of reasons. The amendments:

. . . . . Liberalized federal financial support to the Federal/State program providing for up to 75% federal funding

. . . . Provided for a strong program to improve, strengthen, and assist workshops and rehabilitation centers, and, for the first time, the construction of new facilities

Encouraged states to bring more of the severely disabled into the program for evaluation and services. Under this provision, an extended evaluation can be provided for up to 18 months to clients suffering from 15 specified disabilities, and up to 6 months to clients with other disabilities, in order to determine the rehabilitation potential of persons where expectation of employability cannot be determined by the regular diagnostic and evaluation procedures.

1968. Public Law 90-341 amended the Vocational Rehabilitation Act, extending and expanding the basic programs and establishing a new program of vocational evaluation and work adjustment to serve the disadvantaged. Funding for this program has never been authorized by Congress.

The federal share for basic support grants to the states was increased so that up to 80% federal funding was possible. States were required to maintain the Fiscal Year 1969 level of state expenditures in 1970 and future years so that the increased federal funding would provide for program development and growth and not merely substitute federal dollars for state dollars. Up to 10% of a state's allotment in any given year can be expended for construction of rehabilitation facilities.

Provision was made for the recruitment and training of handicapped persons in public service employment and to encourage individuals to enter rehabilitation work. Another amendment authorized projects with industry to train handicapped persons.

Rehabilitation services were broadened to include follow-up services and services which promise to contribute to the rehabilitation of a group of individuals. Services can be provided to family members when such services will contribute substantially to the determination of rehabilitation potential or the rehabilitation of the handicapped individual.

1972. While each piece of major legislation in the past contained some authority that would make increased services to the severely disabled possible, the Rehabilitation Act of 1972, which was passed by Congress and vetoed by the President, was probably the most far reaching. This legislation gave special recognition to the fact that there are severely handicapped individuals who may not have a vocational goal but who can greatly benefit from rehabilitation services. It was felt that every effort should be expended to provide services to individuals to reach a vocational goal, but there are individuals who can benefit from rehabilitation services which enable them to live more independently and to be more self-sufficient.

The legislation, while not enacted, reflected current Congressional interest and intent.

Innovation-Expansion Grants

A minimum of $50,000 for each state could be used for innovation-expansion grants or, at their option, to public or nonprofit organizations. These three year grants could be directed to the most severely handicapped or those who have unusual or difficult problems in connection with their rehabilitation, particularly those who are poor.

Comprehensive Rehabilitation Services

This part of the legislation would have established a new, supplementary grant program for handicapped individuals not capable of achieving a vocational goal but who may achieve substantial improvement in their ability to live independently or function normally.

Special Federal Responsibilities

. . . . . Technical assistance grants to rehabilitation facilities and to public or nonprofit agencies for the removal of architectural or transportation barriers;

. . . . . Funds for the construction and operation of a National Center for Deaf-Blind Youth and Adults;

. . . . . Establishment and operation, including research, of comprehensive rehabilitation centers for deaf individuals;

. . . . . Establishment and operation of National Centers for Spinal Cord Injuries;

. . . . . Grants for services, including transportation, dialysis, artificial kidneys and supplies for individuals with end-stage renal disease;

. . . . . A new grant program for comprehensive rehabilitation services for older blind individuals (age 55 and over);

. . . . . Establishment of a 20 member National Advisory Council on Rehabilitation of Handicapped Individuals, of whom 8 would be handicapped persons or those who have received vocational rehabilitation services;

. . . . . Funds for the establishment of State Advisory Councils if so desired by the states.

APPENDIX B

Excerpts of testimony at hearings before the Subcommittee on the Handicapped of the Committee on Labor and Public Welfare, United States Senate, 92nd Congress, Rehabilitation Act of 1972, H.R. 8395.

Senator Jennings Randolph, West Virginia: "Many severely disabled persons are not now being adequately served through legislation and through implementation of existing programs. Large segments of our handicapped population which I think have been ignored and neglected – the deaf blind, the older blind person, the spinal cord disabled, and the victims of sudden kidney failure who can only hope for survival by means of enormously expensive dialysis treatment of transplant."

George E. Schreiner, M.D., National Kidney Foundation, testified regarding end-stage renal disease. He indicated the lack of funds has stymied Vocational Rehabilitation agencies since 1966 from initiating and conducting programs to benefit the severely disabled kidney diseased individual. Few states under Medicaid provide dialysis and related treatment.

Lieutenant Governor J. Garrahy, Rhode Island, says that the National Kidney Foundation estimates there are from 55,000 to 60,000 end-stage kidney disabled patients of whom 15,000 could be trained to have dialysis.

E. B. Whitten, Executive Director, National Rehabilitation Association, stated that since 1959 the National Rehabilitation Association has made proposals to Congress to establish, under the Vocational Rehabilitation program, rehabilitation services for severely handicapped individuals, when such services promise to improve their ability to function normally at home and in the community.

Milton Ferris, Chairman, Vocational Rehabilitation and Employment Committee, National Association for Retarded Children, stated that fifty percent of six million retarded individuals are employable. From 1948 to 1970 less than two percent of all rehabilitants were retarded (34,000 of 1,600,000). The mentally retarded population encompasses more of the handicapped population than practically all other disabilities combined.

Congressman Stewart B. McKinney, Connecticut, testified that there are approximately 125,000 to 150,000 spinal cord injured people in the United States, with approximately 4,000 new cases each year. Twenty years ago, spinal cord injured ususally died within a short period of time. Today, modern medicine and rehabilitation are keeping them alive with seventy-five percent of normal life expectancy in most cases. However, only the very rich or the totally poor obtain suitable services; the middle group, practically none.

John Kemp, Member, Board of Directors, Easter Seal Association, stated that in 1972, two thousand affiliated societies of the National Easter Seal Society for Crippled Children and Adults extended services to 378, 390 disabled children and adults. Services include physical restoration, special education, vocational evaluation and training, vocational adjustment, sheltered employment, camping, information, referral, follow-up, transportation, and equipment loans. All services are provided to any handicapped child or adult whose potential for self-realization and independence can be enhanced. A cause and diagnostic lable, age and economic status are not considered. The past and current problems of today in not providing services to this group are primarily due to inadequate funding.

Edward C. Carney, Executive Director, Council of The Programs Serving The Deaf, said that traditionally the deaf have been receiving the short end of services because deafness is not a visual handicap, its inherent problems are less well understood, there are frustrating communication barriers, a lack of recognition of the need to provide counseling to family members, and other complicating factors. These caused rehabilitation agencies to work with clients who were less difficult to serve.

Harold Russell, Chairman, President's Committee on Employment of the Handicapped, testified that statistics from the United States Employment Service are no longer particularly meaningful to us since the socially and culturally deprived, addicts and penal offenders are now included as "handicapped placements", while the total placement figures remain generally the same. If our mail, the economic situation today and visits of our staff to communities around the country are any indication, the fact is fewer and fewer mentally and physically handicapped people are being served by the Employment Service.

Irving Schloss, Legislative Analyst, American Foundation For The Blind, said that State Agencies have not been serving the needs of the severely

disabled because it becomes an arbitrary decision on the part of some rehabilitation counselors that these people cannot be helped vocationally, that they are not feasible for vocational rehabilitation services; and then they are denied services. Rehabilitation counselors should be allowed the time to adequately serve the severely handicapped. It will take more time and more money to serve this population. Thousands of severely disabled people who do not fit into the regular category of Vocational Rehabilitation services have rather desperate needs, yet have been excluded from agency services.

Ernest Weinrich, Assistant Director, Professional Services Program Department, United Cerebral Palsy Association, New York City, stated, "Historically, because of the vast numbers of individuals needing help under the Vocational Rehabilitation Program, those most easily assisted have received services first. Because of the vocational thrust of the Vocational Rehabilitation Program, traditional employment standards have been used to continue to exclude the severely disabled. Competitive employment in the open labor market has been recognized and honored as the only definition of work to the disadvantaged or the severely disabled. The younger and the older severely disabled individual has been excluded by state agencies traditionally by the individual state's limitations on age and phasing out individuals with multiple and substantial handicaps. The severely handicapped person has been deprived of the opportunity to develop a feeling of self-worth and value because of the emphasis and the mandate of traditional employment standards". He added that in the years 1968 - 70 fewer than two percent of eligible cerebral palsied adults needing Vocational Rehabilitation services even saw a Vocational Rehabilitation counselor.

Additional factors cited in testimony as contributing toward the lack of services to the severely disabled include the caseload per worker, the pressure of supervision to close cases rehabilitated, the lack of staff for adequate follow-up of the severely disabled who would need much more than a thirty-day follow-up, problems of mobility and transportation for the severely disabled. A review of the statements of the representatives of the categorical severely disabled groups on a national level appearing before the Committees indicates that only minimal and token services have been provided traditionally to this population. In addition to these specialized agencies, the Veterans Administration has provided services to its severely disabled veterans. Where services were provided, they consisted primarily of counseling and guidance, some physical restoration, some training and possible placement in sheltered workshops. However, the pressure of the "numbers game" and the lack of funding and staff all have been factors in not providing services to this population.

APPENDIX C

Measurement of Client Change and Level of Functioning

The purpose of this form is to document the client's present level of functioning and indicate changes in the client's level of functioning that occur during the rehabilitation process. Items from the R-300 are used; however, the bulk of the form is committed to counselor ratings of client functioning in various areas.

All scales are five-point ratings with anchoring definitions. The definitions are viewed as levels of functioning in relation to employment and are designed to eliminate (as much as possible) the problems encountered in loosely defined rating scales.

Form A employs a rating-scale approach. Considering the administrative limitations as to time and availability of the client, especially at closure, the source of information for an index of case difficulty and client change was reduced to the counselor.

The problem was then o standardize counselor perception in such a way that would allow comparison across counselors and caseloads.

Rating scales have been used with varying degrees of success in social work and psychotherapy. However, little has been done in rehabilitation to develop rating scales for use in the everyday rehabilitation setting.

A major problem in using rating scales is inter-rater reliability. From the start, it was evident that the scales developed must avoid medical and psychiatric terminology. Emphasis in the scales was placed as much as possible on critical employment related behaviors. This emphasis directly related to rehabilitation, and also reflected day-to-day concerns of the counselor.

Form A uses 23 five-point rating scales with anchoring definitions stated as much as possible in behavioral terms. Results of the reliability studies indicate that counselors could make reliable ratings using carefully anchored rating scales. The answer to the question above then is – preliminary results indicate that the use of behaviorally anchored rating scales may provide an administratively feasible method of weighting cases and showing client change.

The second consideration then is to further test the particular scales developed in terms of their relationship to case difficulty and client change. The question is this – do the scales developed indicate case difficulty and measure client change? Two forms are presently being tested in several states in an attempt to answer this second question. These studies will allow investigation of the power of demographic variables as indicators of difficulty, rating scales as indicators of difficulty, and combinations of the scales and demographic data.

Although the validity of the instrument for measuring client change rests mostly on the property of the content, the instruments will be tested to see if they are sensitive to change.

Although it is not expected that the instruments developed will be the solution to the problem, it is hoped that the results of the project will indicate a realistic approach to weighing cases and measuring client change. [1]

---

[1]Technical information regarding the development and use of this form is available from Lowell Lenhart, Technical Project Director, Department of Institutions, Social and Rehabilitative Services, P. O. Box 25352, Oklahoma City, Oklahoma 73125.

Counselor _____ Client _____ Date _____

1. _____ State Agency Number
2. _____ Case Number
3. _____ Caseload Number
4. _____ Status
5. _____ Reason for Closure (Only if
6. _____ Other than Status 26)
6. _____ Age
7. _____ Race (1 White, 2 Negro, 3 Indian, 4 Latin American, 5 Other)
8. _____ Sex (1 Male, 2 Female)
9. _____ Referral Source
10. _____ Age Started Working
11. _____ Previous Agency Contact (1 Yes, 2 No)
12. _____ Marital Status (1 Married, 2 Widowed, 3 Divorced, 4 Separated, 5 Never Married)
13. _____ No. of Dependents
14. _____ Age at Disablement
15. _____ Primary Disability
16. _____ Secondary Disability
17. _____ No. of Other Documented Disabilities
18. _____ Weekly Earnings (Dollars Only)

(* Use R-300 Codes, Oklahoma use R-105 Codes, Maryland use R-13 Codes, Utah use ORS-300 Codes)

I. DIFFICULTY ONLY

A. Anticipated Change in Client's Level of Functioning During Services

_____ 1. Alleviate
_____ 2. Improve Greatly
_____ 3. Improve Somewhat
_____ 4. Remain the Same
_____ 5. Deteriorate

B. Employment Prognosis

_____ 1. Presently employed in competitive labor market and will continue on same job or higher job
_____ 2. Employable at former job or another job without training
_____ 3. Vocational training required; client has training potential
_____ 4. Limited vocational training potential
_____ 5. No vocational training potential

C. Employment History; To An Employer, the Client's Past Work History Would:

_____ 1. Make a very favorable impression
_____ 2. Make a favorable impression
_____ 3. Seems adequate
_____ 4. Seems inadequate, but acceptable with reservations
_____ 5. Extremely bad employment history

D. Availability of Facilities and Client's Attitude Toward Temporary Relocation (Minimum of three weeks)

_____ 1. All necessary facilities are available or client looks forward to temporary relocation
_____ 2. Client accepts temporary relocation and adjustment problems will be relatively few or will not be severe or client resists using available facilities
_____ 3. Client accepts temporary relocation but may have difficulty adjusting to his new surrounding
_____ 4. Client is reluctant to relocate even temporarily and may encounter severe adjustment problems
_____ 5. Client strongly opposed to temporary relocation; adjustment problems would definitely endanger chances for success

E. Availability of Transportation

_____ 1. Client has easy access to an automobile or inexpensive public transportation
_____ 2. Client must be driven by family, friends, or use taxi, which are available
_____ 3. Client must be driven by family, friends, or use taxi, but these resources are not readily available
_____ 4. Many special considerations must be made by the counselor to provide transportation
_____ 5. Client is homebound or must remain in a hospital or institution

II. EDUCATION

A. _____ 13 years and above
B. _____ 10 to 12 years
C. _____ 7 to 9 years
D. _____ 0 to 6 years
E. _____ Special Education

III. ECONOMIC/VOCATIONAL STATUS

A. Vocational Level

_____ 1. Professional, Technical and Managerial
_____ 2. Licensed or certified trades and crafts, or other highly skilled work
_____ 3. Semi-skilled and clerical
_____ 4. Unskilled
_____ 5. Disability status precludes employment

B. Weekly Earnings

_____ 1. $100.01 per week and above
_____ 2. $70.01 per week to $100.00
_____ 3. $50.01 per week to $70.00
_____ 4. $10.01 per week to $50.00
_____ 5. $10.00 per week and below

C. Work Status

_____ 1. Wage or salaried worker (competitive labor market) or self-employed (except BEP)
_____ 2. Wage or salaried worker (sheltered workshop), state agency managed business enterprise (BEP)
_____ 3. Homemaker, unpaid family worker, not working student
_____ 4. Trainee or worker (non-competitive labor market)
_____ 5. Not working other

D. Primary Source of Support

_____ 1. Own Earnings
_____ 2. Dividends, Interest, Rent, and Savings
_____ 3. Family and friends, or non-disability insurance (Retirement, Survivors, Annuity, etc.)
_____ 4. Disability and Sickness Insurance (SSDI, Workmen's Compensation, Civil Service, etc.)
_____ 5. Public Assistance, Private Relief, or Resident of Public Institution

E. Dependency of Client on Others for Financial Support

_____ 1. Completely independent
_____ 2. Approximately 25% of income comes from sources other than earnings
_____ 3. Approximately 50% of income comes from sources other than earnings
_____ 4. Approximately 75% of income comes from sources other than earnings
_____ 5. Totally dependent on sources other than earnings

IV. PHYSICAL FUNCTIONING

A. General Health Status Other Than Disability

_____ 1. Feels good most of the time; has feelings of vitality
_____ 2. Generally feels good, but reports minor problems that seem reasonable
_____ 3. Multiple complaints, which seem mostly reasonable
_____ 4. Multiple complaints that seem mostly unjustified by physical condition
_____ 5. Multiple complaints that seem totally unjustified by his physical condition

B. Mobility

_____ 1. Totally independent
_____ 2. Ambulatory, but somewhat restricted or with minimal use of devices
_____ 3. Ambulatory with major devices, as unassisted wheelchair
_____ 4. Ambulatory only with assistance of another person, as assisted wheelchair
_____ 5. Bedridden

C. Physical Independent for Tasks Other than Mobility

_____ 1. Totally independent
_____ 2. Minimal assistance required
_____ 3. Dependent for one major or several minor tasks
_____ 4. Dependent for several major tasks
_____ 5. Constant need for attendant services

D. Work Tolerance

_____ 1. Minimal restrictions to type of work client can do
_____ 2. Occupations limited to light physical activity but able to work full-time
_____ 3. Sedentary work, low stress, or close supervision required; but able to work full-time
_____ 4. Unable to work full-time because of mental or physical condition
_____ 5. Current disability status precludes employment

E. Prominence of Vocationally Handicapping Condition (Including Mental and Emotional)

Handicap is:

_____ 1. Hidden and cannot be directly observed
_____ 2. Hidden and would only be observed episodically
_____ 3. Noticeable only after a period of interviewing, or only slightly noticeable
_____ 4. Marked and obvious, noticeable at once and continually manifest
_____ 5. Marked, obvious, and continually manifest and will be repugnant to most employers

F. Compensatory Skills

_____ 1. Has developed in other skill areas or with the use of devices, almost total compensation for disability
_____ 2. Has significant development in other skill areas, or with the use of devices, abilities which help compensate for disability
_____ 3. No real development in other skill areas and minimal use of devices
_____ 4. Some deterioration in other skill areas
_____ 5. Substantial deterioration in other skill areas

V. ADJUSTMENT TO DISABILITY

A. Identification with Worker Role

_____ 1. Client feels personal need to be independent, and do his share
_____ 2. Identity to worker role developing or deteriorated somewhat since disability but wants to work
_____ 3. Weak identity to worker role, little idea of day-to-day work demands
_____ 4. Client has adjusted to being dependent; talks of working but is unconvincing
_____ 5. Client strongly identifies with handicap and clings to dependent role

B. Compatibility of Employment Expectations with Client's Personality and Physical Condition

_____ 1. Client seems ideally suited for the work he desires
_____ 2. Client's employment expectations are reasonable, although not ideal
_____ 3. Client has no ideas concerning possible vocational goals, or his ideas are more "day dreams" than employment expectations
_____ 4. Client's employment expectations are very unrealistic and impractical
_____ 5. Client's employment expectations are so totally unrealistic and impractical, counselor must work with other professional persons, agencies, or institutions before client can proceed in the rehabilitation process

C. Client's Confidence in Himself as a Worker

_____ 1. Highly favorable, client's self-confidence inspires confidence from others
_____ 2. Client believes he can and will be a good employee in spite of his handicap
_____ 3. Client feels he will become a fairly good employee but exhibits little initiative
_____ 4. Client excessively timid or shows unimpressive over-confidence
_____ 5. Client can never see himself as being able to hold a job

VI. SOCIAL COMPETENCY

A. Language Facility

_____ 1. Reads and writes well; has no trouble understanding and communicating common vernacular and could learn to use technical language
_____ 2. Reads, speaks, and writes adequately; has no particular problem filling out employment applications, or holding job interview
_____ 3. Reads, speaks, and writes adequately for job applications and interview, but speaks slowly and may have some difficulty with other than simple written instructions
_____ 4. Reads, speaks and/or writes poorly, and will have difficulty interpreting even simple written instructions
_____ 5. Almost complete lack of language, functionally illiterate, extremely small vocabulary

B. Decision-Making Ability

_____ 1. Takes strong active role in decision-making
_____ 2. Slow to make decisions but makes his own decisions
_____ 3. Wants others to make decisions but will take some part in decision-making process
_____ 4. Others make decisions for him and manage his personal affairs
_____ 5. Will neither help make decisions not take action on help from others; counselor must work with other professional agencies, persons, or institutions before client can proceed in the rehabilitation process

C. Role in Family

_____ 1. Assumes appropriate role

_____ 2. Assumes appropriate role but some counselor reservation

_____ 3. Participates in familial affairs but evidence of underlying ambivalence toward family

_____ 4. Refuses to assume appropriate role

_____ 5. Conscious effort to disrupt family

D. Family Support

_____ 1. Good; family shows great deal of understanding of client; very supportive and helpful

_____ 2. Moderate; although not ideal, support is adequate

_____ 3. Fair; support given but is inappropriate; evidence of underlying ambivalence on the part of the family

_____ 4. Poor; support given but there is definite indifference on the part of the family toward client or his rehabilitation

_____ 5. Very poor; family definitely non-supportive, strong opposition

EXPLANATION OF ITEMS ON FORM A

On the top of the first page is simple demographic and identification data:

Counselor - Counselor's name

Client - Client's name

Date - Date form is filled out

1. State Agency Number - Your State Agency number
2. Case Number - The case number you have assigned the client for your agency's purposes
3. Caseload Number - Counselor's caseload number
4. Status - Client's present status code
5. Reason for Closure (Only if Other than Status 26) - If the case is active or closed in Status 26 enter 0; otherwise, use appropriate code. (Use R-300 Codes. Oklahoma use R-105 Codes, Maryland use R-13 Codes, Utah use ORS-300 Codes.)
6. Age - Client's present age
7. Race - Code - Enter 1 for White, 2 Negro, 3 Indian, 4 Latin American, 5 Other
8. Sex - Enter 1 for Male, 2 for Female
9. Referral Source - Code - Use R-300 Codes (Oklahoma use R-105 Codes, Maryland use R-13 Codes, Utah use ORS-300 Codes.)
10. Age Started Working - Client's age when he started his first job lasting over two months. If never employed, enter 00.
11. Previous Agency Contact - Enter 1 for Yes, 2 if No. Enter 1 (Yes) only if formal application for services was made.
12. Marital Status - Use Codes - 1 Married, 2 Widowed, 3 Divorced, 4 Separated, 5 Never Married.

13. No. of Dependents - Number determined in the same manner as R-300 (Oklahoma R-105 Codes, Maryland R-13 Codes, Utah ORS-300 Codes.)

14. Age at Disablement - Age at onset of disability. If there was a gradual deterioration of the client's condition, use age at which the client first showed signs of functional deterioration.

15. Primary Disability - Client's primary disability Code.

16. Secondary Disability - Client's secondary disability code, if any; otherwise enter 000.

17. No. of Other Documented Disabilities - Enter the number of disabilities which are documented in the case record, if any. Otherwise, enter 0.

18. Weekly Earnings - Dollar amount of weekly earnings (leave off cents).

I. DIFFICULTY ONLY - these items are added to the instrument to give a clearer idea of difficulty at intake into the program. These five items are differentiated from the rest of the items in that rather than establishing a level of functioning, they are predictive in nature. With the addition of these items, a clearer picture can be obtained not only as to how much change will be required, but also the difficulty with which those changes will be made.

A. Anticipated Change in Client's Level of Functioning During Services

_____ 1. Alleviate
_____ 2. Improve Greatly
_____ 3. Improve Somewhat
_____ 4. Remain the Same
_____ 5. Deteriorate

This is a prediction of the client's level of functioning as reflected by available information in relation to the disability after services. With training, devices, and treatment, the limiting effects of many disabilities

will be at least "Improved Somewhat". However, in some cases, the counselor must develop skills in areas not directly related to the disability. As an example, a bedridden client's major handicap in a functional framework might be his lack of mobility. At closure, he may use a wheelchair unassisted, in which case he has "Improved Greatly." If he still needs quite a bit of attendant services, he may have "Improved Somewhat." If this client will still be bedridden, he could either "Remain the Same" or "Deteriorate" although important services were provided.

B. Employment Prognosis

_____ 1. Presently employed in competitive labor market and will continue on same job or higher job
_____ 2. Employable at former job or another job without training
_____ 3. Vocational training required; client has training potential
_____ 4. Limited vocational training potential
_____ 5. No vocational training potential

This item is fairly well self-explanatory. It should be noted that the prognosis should be based on the client's capabilities. "Limited vocational training potential" should not be checked because of a motivation deficiency, but because a limitation in physical or mental capacity exists.

C. Employment History: To An Employer, the Client's Past Work History Would:

_____ 1. Make a very favorable impression
_____ 2. Make a favorable impression
_____ 3. Seems adequate
_____ 4. Seems inadequate, but acceptable with reservation
_____ 5. Extremely bad employment history

This item relies on the counselor's judgment of the client's work history. The counselor is to put himself in the position of the average employer and ask himself what kind of impression the client's work history will make. Because a history of institutionalization for mental illness or police record can present a handicap

to employment in itself, it would be rated along with actual work history. For example, a client newly released from prison would be rated at level 5, even if he has an otherwise good work history.

D. Availability of Facilities and Client's Attitude Toward Temporary Relocation (Minimum of three weeks)

_____ 1. All necessary facilities are available or client looks forward to temporary relocation
_____ 2. Client accepts temporary relocation and adjustment problems will be relatively few or will not be severe or client resists using available facilities
_____ 3. Client accepts temporary relocation but may have difficulty adjusting to his new surroundings
_____ 4. Client is reluctant to relocate even temporarily and may encounter severe adjustment problems
_____ 5. Client strongly opposed to temporary relocation; adjustment problems would definitely endanger chances for success

This item is intended to reflect problems that may arise due to lack of facilities necessary for helping the client. It should be remembered that this item does not refer to facilities in general, but those needed for working with this particular client. If the necessary facilities are available or relocation will be short (less than three weeks), check level 1, or level 2 if the client resists use of available facilities. If the client must temporarily relocate, the second element to consider is the client's attitude and potential adjustment problems. Affecting adjustment problems may be client's ability to adjust, presence of counselors at the facilities, or a close relative near the facility.

E. Availability of Transporation

_____ 1. Client has easy access to an automobile or inexpensive public transportation
_____ 2. Client must be driven by family, friends, or use taxi, which are available
_____ 3. Client must be driven by family, friends, or use taxi, but these resources are not readily available
_____ 4. Many special considerations must be made by the counselor to provide transportation
_____ 5. Client is homebound or must remain in a hospital or institution

This item is concerned with how well the client can move about in the community, get to and from rehabilitation facilities, job interviews, etc. Level 1 relates to the client who is mobile, either because he owns or has use of an automobile or can use relatively inexpensive public transportation without problem. At level 2, the client has less mobility than at level 1 due to the dependence on family, friends, or taxi service, but the resources are readily available and represent an inconvenience rather than a real problem. At level 3 the client may be in some general physical or mental condition as in level 2; however, because of the family situation, lack of money for taxi, special vehicle requirements, etc., transportation presents a significant problem. Level 4 refers to the client for whom the counselor must arrange or provide transportation because of the client's physical or mental disability. Level 5 represents the institutional, homebound, or otherwise totally immobile client.

II. EDUCATION

A. _____ 13 years and above
B. _____ 10 to 12 years
C. _____ 7 to 9 years
D. _____ 0 to 6 years
E. _____ Special Education

The number of years of training the client has had in formal schools, either grade school, secondary, high school or college. Remedial education should be scored as special education. If a G.E.D. Certificate was obtained, enter as 12 years of schooling.

III. ECONOMIC/VOCATIONAL STATUS

A. Vocational Level

_____ 1. Professional, Technical and Managerial
_____ 2. Licensed or certified trades and crafts, or other highly skilled work
_____ 3. Semi-skilled and clerical
_____ 4. Unskilled
_____ 5. Disability status precludes employment

Vocational Level refers to the type of job the client could or is presently holding; that is, the job the client is presently capable of holding. Level 1

is professional (doctors, lawyers, educators, counselors, etc.), highly technical (engineers, architects), and managerial (managers, accountants, officials). Level 2 is skilled labor. These occupations are usually licensed or certified by federal, state or local governments or a trade association; however, exceptions to this rule of thumb must be made in certain cases such as farmers or farm workers who may fall at any level, and certain types of secretaries whose work and salary may place them in level 2 or level 1. Level 3 relates to semi-skilled occupations that require a minimum of training at least at entry level jobs. An apprentice would be rated at level 3 until he receives his journeyman's license. Level 4 is unskilled labor and work which requires no formal training over two weeks or only a short on-the-job orientation period is required. At level 5 the limitations imposed by the client's disability prevent him from maintaining employment. If the client is unemployed but could perform unskilled labor, rate him at level 4 or the appropriate level for the job he could presently perform.

B. $ _____ Weekly Earnings

_____ 1. $100.01 per week and above
_____ 2. $70.01 per week to $100.00
_____ 3. $50.01 per week to $70.00
_____ 4. $10.01 per week to $50.00
_____ 5. $10.00 per week and below

In this item, simply check the appropriate range for the client's weekly earnings.

C. Work Status

_____ 1. Wage or salaried worker (competitive labor market) or self-employed (except BEP)
_____ 2. Wage or salaried worker (sheltered workshop), state agency managed business enterprise (BEP)
_____ 3. Homemaker, unpaid family worker, not working student
_____ 4. Trainee or worker (non-competitive labor market)
_____ 5. Not working other

The items in this level correspond with the R-300 (Oklahoma R-105, Maryland R-13, Utah ORS-300) codes with level 1 being codes 1 and 3; level 2 being codes 2 and 4; level 3 being codes 5, 6 and 7; level 4 being code 9, and level 5 being code 8.

D. Primary Source of Support

_____ 1. Own Earnings
_____ 2. Dividends, Interest, Rent, and Savings
_____ 3. Family and friends, or non-disability insurance (retirement, survivors, annuity, etc.)
_____ 4. Disability and Sickness Insurance (SSDI, Workmen's Compensation, Civil Service, etc.)
_____ 5. Public Assistance, Private Relief, or Resident of Public Institution

Primary source of support refers to largest single source of income regardless of the amount it contributes to his total income. Level 1 and level 2 are self-explanatory. Level 3 includes not only family and friends, but also non-disability related insurance; that is, the reason the client is receiving benefits has nothing to do with his disability. Level 4 is disability or sickness insurance of all types, while level 5 relates to those clients who are dependent on public or private relief agencies or residents of public institutions.

E. Dependency of Client on Others for Financial Support

_____ 1. Completely independent
_____ 2. Approximately 25% of income comes from sources other than earnings
_____ 3. Approximately 50% of income comes from sources other than earnings
_____ 4. Approximately 75% of income comes from sources other than earnings
_____ 5. Totally dependent on sources other than earnings

This item seeks a finer measure of the client's financial independence than can be inferred from "Weekly Earnings" alone. Financial independence refers to the client's ability to provide for

himself without relying on others. If a client receives money from an outside source such as a relative, dividends, etc., but the client could live on his own earnings, he would be classified as "Completely independent". If the client must rely on non-monetary support such as free child care or medicine, he would be classified in the appropriate category relative to the approximate amount these services would cost the client if he could afford to pay for them himself. Homemakers and unpaid family workers at closure will be rated as completely dependent, if unpaid.

IV. PHYSICAL FUNCTIONING

A. General Health Status Other than Disability

_____ 1. Feels good most of the time; has feelings of vitality
_____ 2. Generally feels good, but reports minor problems that seem reasonable
_____ 3. Multiple complaints which seem mostly reasonable
_____ 4. Multiple complaints that seem mostly unjustified by his physical condition
_____ 5. Multiple complaints that seem totally unjustified by his physical condition

This item is intended to give a general idea of the client's health other than problems directly a function of the disability. The last two levels are distinguished from the first three by the element of doubt concerning the legitimacy of the complaints. A client checked at the last two levels would be one who impresses the counselor as a hypochondriac, one who tends to be a complainer, or who tries to hide behind many chronic, apparently unrealistic complaints.

B. Mobility

_____ 1. Totally independent
_____ 2. Ambulatory, but somewhat restricted or with minimal use of devices
_____ 3. Ambulatory with major devices, as unassisted wheelchair
_____ 4. Ambulatory only with assistance of another person, as assisted wheelchair
_____ 5. Bedridden

Ambulatory has to do with the person's ability to move about in a limited area such as a shop, office building, school, or hospital. "Totally independent" would be checked for a person who moves about with normal speed and agility for a person of his age. "Ambulatory, but somewhat restricted or with minimal use of devices" would be a client who walks slowly, uses a brace, cane (not blind), limps, or an appliance that does not have the bulk of a wheelchair or walker. "Ambulatory, with major devices, as unassisted wheelchair" refers to larger devices, cane (blind) or several smaller devices (as double leg braces and crutches), but retains the aspect of independence from help from other people, which distinguishes the level of "Ambulatory only with assistance of another person." "Bedridden" refers to a client who for all practical purposes is confined to a bed.

C. Physical Independence for Tasks Other than Mobility

_____ 1. Totally independent
_____ 2. Minimal assistance required
_____ 3. Dependent for one major or several minor tasks
_____ 4. Dependent for several major tasks
_____ 5. Constant need for attendant services

Physical Independence in this category is exclusive of the area covered by the item of "Mobility". This item covers self-care activities, writing, reading and other basic skills. To rate this item, the rater should rate the problem in terms of minor tasks being a small inconvenience, and major tasks being a significant periodic inconvenience to the employer or coworkers.

D. Work Tolerance

_____ 1. Minimal restrictions to type of work client can do
_____ 2. Occupations limited to light physical activity but able to work full-time
_____ 3. Sedentary work, low stress, or close supervision required; but able to work full-time
_____ 4. Unable to work full-time because of mental or physical condition
_____ 5. Current disability status precludes employment

Work Tolerance refers to limitations as to the types of work a client can do and the time the client can stay on the job. The first three levels refer to limitations as to the type of work the client can do. If the client can do only sedentary work, increasing severity is reflected in the time a client can stay working. In reference to mental disabilities, a client who could work a regular full-time job but requires low stress, close supervision, or other special job conditions, would be rated at level 3 "Sedentary work, low stress, or requires close supervision, but able to work full-time."

E. Prominence of Vocationally Handicapping Condition (Including Mental and Emotional) Handicap is:

_____ 1. Hidden and cannot be directly observed
_____ 2. Hidden and would only be observed episodically
_____ 3. Noticeable only after a period of interviewing, or only slightly noticeable
_____ 4. Marked and obvious, noticeable at once and continually manifest
_____ 5. Marked, obvious, and continually manifest and will be repugnant to most employers

How obvious the handicap is should be rated as it might be noticed by a potential employer. The last definition might be considered as handicaps that would preclude saleswork or occupations involving a great deal of public contact.

F. Compensatory Skills

_____ 1. Has developed in other skill areas or with the use of devices, almost total compensation for disability
_____ 2. Has significant development in other skill areas, or with the use of devices, abilities which help compensate for disability
_____ 3. No real development in other skill areas and minimal use of devices
_____ 4. Some deterioration in other skill areas
_____ 5. Substantial deterioration in other skill areas

Compensatory skills are those skills and techniques the client has developed to help overcome the limiting effects of his disability.

The use of devices, physical development, or learning new ways to accomplish old tasks are examples of compensatory skills. The key to this item is how much has the learning of new skills reduced the limiting effects of the disability? Learning new job skills to compensate for loss of old job skills is not included in this item; however, social adjustment training could be compensatory skill for a client with a behavior disorder, or a mental patient.

V. ADJUSTMENT TO DISABILITY

A. Identification with Worker Role

_____ 1. Client feels personal need to be independent, and do his share
_____ 2. Identity to worker role developing or deteriorated somewhat since disability but wants to work
_____ 3. Weak identity to worker role, little idea of day-to-day work demands
_____ 4. Client has adjusted to being dependent; talks of working but is unconvincing
_____ 5. Client strongly identifies with handicap and clings to dependent role

The client's attitude toward dependency and the worker role is rated from a personal need to be independent to a total life style and personal orientation build around the dependency caused or excused by the disability. The second level differentiates clients who are in the process of solidifying their identity to the worker role and clients who formerly had a strong worker identity which has weakened somewhat since the onset of the disability; however, the clients at the third level have developed at best only a weak identity as a worker and is differentiated from level 2 by the absence of developing in a positive direction or the absence of a basic worker identity. Clients at level 4 have adjusted to being dependent and may talk about working; however, this seems only for the benefit of the counselor and is unconvincing. Level 5 is distinguished by the intensity and more total involvement of the client with the dependency role.

B. Compatibility of Employment Expectations with Client's Personality and Physical Condition

_____ 1. Client seems ideally suited for the work he desires
_____ 2. Client's employment expectations are reasonable, although not ideal
_____ 3. Client has no ideas concerning possible vocational goals, or his ideas are more "day dreams" than employment expectations
_____ 4. Client's employment expectations are very unrealistic and impractical
_____ 5. Client's employment expectations are so totally unrealistic and impractical, counselor must work with other professional persons, agencies, or institutions before client can proceed in the rehabilitation process

Compatibility of employment expectations with personality and physical condition covers not only the area of realistic understanding of the physical limitations of the disability, but also the understanding of personality strong and weak points in relation to employment. The first level refers to individuals who have realistic concepts of their limitations and themselves, as differentiated from clients having a reasonable vocational goal, but not as well integrated with aptitudes, abilities, and interests. Also, the second level would cover a vocational goal which seems reasonable to the counselor; however, he has some reservations. The third level pertains to clients having no firm ideas as to what they should do or who state unrealistic employment expectations which the client gives up when questioned closely. The fourth level deals with the client who not only has unrealistic and impractical goals, but also believes they are realistic, resulting in a significant barrier to the client's rehabilitation. A client should not be placed accordingly in the last level unless his unrealistic outlook is symptomatic of a larger loss of contact with reality. In this case, the counselor will be acquiring short-term therapy or be working simultaneously with a mental institution or mental health agency.

C. Client's Confidence in Himself as a Worker

_____ 1. Highly favorable, client's self-confidence inspires confidence from others

_____ 2. Client believes he can and will be a good employee in spite of his handicap

_____ 3. Client feels he will become a fairly good employee but exhibits little initiative

_____ 4. Client excessively timid or shows unimpressive over-confidence

_____ 5. Client can never see himself as being able to hold a job

This item deals with self-confidence and self-concept in terms of the client's perception of himself as a worker or ability to get a job done. The first level refers to those clients who can take initiative and inspire others to have confidence in him. The counselor often has clients who "talk a good stick" but leave the counselor with many reservations, or the counselor feels the client is trying to put something over on him. This client reaction is equivalent to excessive shyness and timidity and should be rated in level 4. Levels 2 and 3 fall in between being differentiated by the amount of initiative the client feels he can take. Level 5 refers to those clients who are self-deprecating to the extreme, and as a result of this feeling of failure, the client will probably leave any job he is placed on at the first bit of rough going and feel he has proved what he has known all along – that he is destined to be a failure.

VI. SOCIAL COMPETENCY

A. Language Facility

_____ 1. Reads and writes well; has no trouble understanding and communicating common vernacular and could learn to use technical language

_____ 2. Reads, speaks, and writes adequately; has no particular problem filling out employment applications, or holding job interview

_____ 3. Reads, speaks, and writes adequately for job applications and interview, but speaks slowly and may have some difficulty with other than simple written instructions

_____ 4. Reads, speaks and/or writes poorly, and will have difficulty interpreting even simple written instructions

_____ 5. Almost complete lack of language, functionally illiterate, extremely small vocabulary

This item deals with basic language skills needed on the job. The first level covers not only very fluent clients, but also any client who can express himself clearly if client's vocabulary is not large. The second level is for clients whose use of language is adequate for job interviews, filling out applications, and making business telephone calls and following most written instructions. Clients rated in level 3 would have difficulty interpreting complex instructions and would be limited to low level office work. A client at level 4 would have a great deal of trouble filling out job applications and holding a good interview; on the job, he may have trouble following even simple written instructions. The last level refers to clients who have extremely limited verbal as well as written vocabularies.

C. Role in Family

_____ 1. Assumes appropriate role
_____ 2. Assumes appropriate role but some counselor reservation
_____ 3. Participates in familial affairs but evidence of underlying ambivalence towards family
_____ 4. Refuses to assume appropriate role
_____ 5. Conscious effort to disrupt family

The appropriateness of the client's role in the family can be a difficult area to rate because of variations in age, sex, race, and physical and emotional condition of the other family members. The distinction between level 1 and level 2 is made basically on how the rater feels about his judgment. In these two levels, the client seems to assume the appropriate role for his particular family situation, but level 2 represents a somewhat guarded judgment. Level 3 has the client participating in family affairs, but only at a superficial level when it seems unjustified by the family's reaction to the client, while in level 4 not even superficial participation is present. Level 5 refers to clients actively trying to disrupt the family, and may be seen as a psychiatric problem. Remember that the appropriateness of the role the client plays is what is being rated and, in some instances, a client who is uninvolved with his family may, because of the emotional climate at home, be rated on level 1 or 2. Persons other than biological parents may be rated as family if they perform the family's function in relation to the client. If the client has no immediate family, rate him at level 2.

D. Family Support

_____ 1. Good; family shows great deal of understanding of client; very supportive and helpful
_____ 2. Moderate; although not ideal, support is adequate
_____ 3. Fair; support given but is inappropriate; evidence of underlying ambivalence on the part of the family
_____ 4. Poor; support given but there is definite indifference on the part of the family toward client or his rehabilitation
_____ 5. Very poor; family definitely non-supportive, strong opposition

Family Support is rated not only by whether support is given, but also whether it is appropriate or not. By rating the item in this manner, information reflects the understanding of the client by his family and is rated along with the presence of active support. The client's family can be every bit as unrealistic about the client's disability and capacities as the client himself. At the first level, the family is very involved and shows a good understanding of the client's situation. In level 4, the family support is still adequate, but does not show the quality in understanding of the client and/or appropriateness of the support that exists at level 1. The third level refers to the family who wants the client to live up to their expectations, which are out of touch, either high or low, with the client's capabilities. The fourth level represents superficial support that only serves as a cover-up for underlying indifference. At level 5 the family offers active opposition and wants to keep the client dependent on the family. If the client has no family, place him at level 2, because he does not have the positive effect of a supportive family. Persons other than biological parents may be rated as family if they perform the family's function in relation to the client.

APPENDIX D

MEMBERS OF PRIME STUDY GROUP I

Reeves, Pat
(General Chairman)
7515 East 17th Street
Anchorage, Alaska 99504

Zawada, Adam R.
(Chairman, Prime Study Group)
Director of Planning and Research
Division of Vocational Rehabilitation
725 South Bronough Street
Tallahassee, Florida 32304

Moriarty, Joseph, Dr.
(University Sponsor)
Director, Rehabilitation Research
and Training Center
University of West Virginia
Institute, West Virginia 25112

Blankenship, Les, Program Analyst
Evaluation and Monitoring Branch
Rehabilitation Services Administration
Social and Rehabilitation Service, DHEW
Washington, D. C. 20201

Burket, Dean
Vocational Rehabilitation Specialist
Implementation Branch
Division of Developmental Disabilities
Rehabilitation Services Administration
Washington, D. C. 20201

Calli, Al
Director
Easter Seal Goodwill Industries
Rehabilitation Center
20 Brookside Avenue
New Haven, Connecticut 06515

Conley, Ronald, Director
Division of Monitoring and Program
Analysis
Rehabilitation Services Administration
Washington, D. C. 20201

Ebra, George
Rehabilitation Counselor
Division of Vocational Rehabilitation
4809 North Armenia
Tampa, Florida 33603

Engelhardt, Richard C.
Assistant Regional Representative for
Rehabilitation Services
Rehabilitation Services Administration
26 Federal Plaza, Room 3818
New York, New York 10007

Hubbard, Guy
Director, Personnel Development and
Continuing Education
Division of Vocational Rehabilitation
Department of Human Resources
P. O. Box 26053
Raleigh, North Carolina 27603

Iddings, Curtis
Director
Spinal Cord Injury Project
Woodrow Wilson Rehabilitation Center
Fishersville, Virginia 22939

Kruger, Irving J.
Chief of Vocational Rehabilitation
New Jersey Commission for the Blind
and Visually Impaired
1100 Raymond Boulevard
Newark, New Jersey 07102

LaRue, Alfred
Assistant Supervisor in Education
Massachusetts Rehabilitation Commission
296 Boylston Street
Boston, Massachusetts 02116

Lenhart, Lowell, Technical Project Director
Department of Institutions, Social and Rehabilitative Services
P. O. Box 25352
Oklahoma City, Oklahoma 73125

Massie, Willman
Chief, Service Systems Branch
Rehabilitation Services Administration
Washington, D. C. 20201

Minton, Elizabeth B.
Assistant Director of Training
Research and Training Center
Institute, West Virginia 25112

Nagi, Saad Z., Dr.
Professor of Sociology and Public Policy
The Ohio State University, Mershon Center
1250 Chambers Road, Suite 130
Columbus, Ohio 43212

Riley, Larry, Dr.
Research Associate
The Ohio State University, Mershon Center
1250 Chambers Road
Columbus, Ohio 43212

Warner, Henry
Assistant Regional Representative for Rehabilitation Services
Rehabilitation Services Administration
Room 448
50 Seventh Street, N. E.
Atlanta, Georgia 30323

APPENDIX E

MEMBERS OF TOTAL STUDY GROUP I

Alonso, Gerald, Program Supervisor
Division of Vocational Rehabilitation
725 S. Bronough Street
Tallahassee, Florida 32304

Aman, Delbert K., District Supervisor
Service to the Visually Impaired
104 South Lincoln
Aberdeen, South Dakota 57401

Arneson, Kathleen C., Director
Policy Research and Legislation
Rehabilitation Services Administration
330 'C' Street, S.W.
Washington, D. C. 20201

Aud, Edward J., RS Director
Rehabilitative Services
Department of Institutions, Social and Rehabilitative Services
P. O. Box 25352
Oklahoma City, Oklahoma 73125

Baack, Kevin C., Ph.D.
Assistant Director
Bureau of Mental Retardation
State Office Building
Augusta, Maine 04330

Baker, William T.
Coordinator of Field Operations
Division of Vocational Rehabilitation
State Office Building
Topeka, Kansas 66612

Barnes, Marvin W., Supervisor
Field Services
1801 Rebsamen Park Road
P. O. Box 3781
Little Rock, Arkansas 72203

Barnes, Susan, Home Teacher
Services for the Blind
1720 West End Building, Room 301
Nashville, Tennessee 37203

Bateman, Rodney, Supervisory Auditor
Division of State and Local Audits
600 Sixth Street, S.W.
Washington, D. C. 20201

Blankenship, Les, Program Analyst
Evaluation and Monitoring Branch
Rehabilitation Services Administration
Social and Rehabilitation Service
Department of Health, Education and Welfare
Washington, D. C. 20201

Breeding, Paul A.
Director, Program Planning
Department of Vocational Rehabilitation
4615 West Broad Street
P. O. Box 11045
Richmond, Virginia 23230

Brooks, James R., Supervisor
Division of Vocational Rehabilitation
1808 West End Building, 14th Floor
Nashville, Tennessee 37203

Burket, Dean
Vocational Rehabilitation Specialist
Implementation Branch
Division of Developmental Disabilities
Rehabilitation Services Administration
Washington, D. C. 20201

Burpee, Orlo
Vocational Rehabilitation Service
Department of Education
Box 1016
Lansing, Michigan 48904

Calli, Al, Director
Easter Seal Goodwill Industries
Rehabilitation Center
20 Brookside Avenue
New Haven, Connecticut 06515

Carballo, Joe F., Jr.
Counselor
Mississippi Industries for the Blind
P. O. Drawer 4417
Jackson, Mississippi 39216

Carney, J. Terry
Field Supervisor IV
Services for the Blind
1720 West End Building, Room 301
Nashville, Tennessee 37203

Cate, Clark
Associate Administrator
Social and Developmental Services
Division of Retardation
600 New London Avenue
Cranston, Rhode Island 02920

Chiles, James
Vocational Rehabilitation Specialist
Rehabilitation and Self-Support
Services, SRS
P. O. Box 7760
Philadelphia, Pennsylvania 19101

Clare, Ronald
Associate Administrator
Child and Adult Development Unit
Ladd School
Exeter, Rhode Island 02822

Clark, Peter S. B.
Division of Vocational Rehabilitation
105 Loudon Road, Building 3
Concord, New Hampshire 03301

Claunch, James
Planning Coordinator for Developmental
Disabilities
Mississippi Interagency Commission on
Mental Illness and Mental Retardation
P. O. Box 16189
Jackson, Mississippi 39206

Coleman, William H.
Rehabilitation Supervisor
South Carolina Commission for the Blind
P. O. Box 11638
Capitol Station
Columbia, South Carolina 29211

Collins, C. J., Supervisor
Division of Rehabilitation Services
Vocational Rehabilitation Department
400 Wade Hampton State Office Building
Columbia, South Carolina 29201

Coombs, Marianne
Field Supervisor
Vocational Rehabilitation Division
56 State Street
Montpelier, Vermont 05602

Conley, Ronald, Director
Division of Monitoring and Program
Analysis
Rehabilitation Services Administration
Washington, D. C. 20201

Corbin, R. Dave
Program Supervisor
Vocational Rehabilitation
P. O. Box 44371
Baton Rouge, Louisiana 70804

Coryell, Wayne L., Program Supervisor
Division of Vocational Rehabilitation
725 South Bronough Street
Tallahassee, Florida 32304

Costa, Dan M., Program Supervisor
Division of Vocational Rehabilitation
725 S. Bron ugh Street
Tallahassee, Florida 32304

Cox, Wendell
104 Fry Building
Natchez, Mississippi 39120

Crawford, Glen, State Supervisor
MH-MR Services
P. O. Box 12866
Capitol Station
Austin, Texas 78705

Cunningham, Portis
Program Administrator for Developmental Disabilities
Alabama Department of Mental Health
502 Washington Street
Montgomery, Alabama 36104

Darnell, Roger
Division of Rehabilitation
916 Social Services Building
Denver, Colorado 80203

Day, Robert
Associate Administrator
Adult Rehabilitation Unit
Ladd School
Exeter, Rhode Island 02822

Dickerson, Altamont, Jr.
Director, Rehabilitation Facilities
Department of Vocational Rehabilitation
4615 West Broad Street
P. O. Box 11045
Richmond, Virginia 23230

Draney, Robert
Deputy Director
Division of Rehabilitation Services
233 South 10th Street
Lincoln, Nebraska 68508

Eischen, Robert, Regional Supervisor
Metropolitan Office
Division of Vocational Rehabilitation
1745 University Avenue
St. Paul, Minnesota 55104

Ebra, George
Rehabilitation Counselor
Division of Vocational Rehabilitation
4809 North Armenia
Tampa, Florida 33603

Engelhardt, Richard C.
Assistant Regional Representative for Rehabilitation Services
Rehabilitation Services Administration
26 Federal Plaza, Room 3818
New York, New York 10007

Fahrenbruch, H. R.
Division of Vocational Rehabilitation
P. O. Box 1830
Santa Fe, New Mexico 87501

Fenoglio, John, Program Director
Texas Rehabilitation Commission
1301 West 38th Street
Austin, Texas 78705

Fenton, Joseph, Dr.
Chief, Special Centers
Social and Rehabilitation Service
330 'C' Street, S.W.
Washington, D. C. 20201

Fletcher, William B., Program Supervisor
Division of Vocational Rehabilitation
725 South Bronough Street
Tallahassee, Florida 32304

Freeman, Bob, Ph.D., Superintendent
Clover Bottom Hospital and School
275 Stewards Ferry Pike
Donelson, Tennessee 37214

Freeman, Charles
Coordinator, Facilities and Services
for the Blind
Division of Welfare
Department of Public Health and Welfare
State Office Building
Jefferson City, Missouri 65101

Fulford, Harry R., Program Supervisor
Division of Vocational Rehabilitation
725 South Bronough Street
Tallahassee, Florida 32304

Funk, Charles, Regional Director
Texas Rehabilitation Commission, Region VII
13515 Southwest Freeway, Suite 213
Houston, Texas 77478

Geigel, Wesley, Director
Division of Service Systems
Rehabilitation Services Administration
330 'C' Street, S.W.
Washington, D. C. 20201

Greenwell, Richard, Administrative
Assistant
Institute for Developmental Disabilities
Department of Mental Health
P. O. Box 678
Frankfort, Kentucky 40601

Hammond, N. Spencer
Deputy Assistant Secretary
Department of Social & Health Services
Vocational Rehabilitation Services
Division
P. O. Box 1788
Olympia, Washington 98504

Hanks, Dale, Assistant Commissioner
Program Planning and Development
Department of Vocational Rehabilitation
4615 West Broad Street
P. O. Box 11045
Richmond, Virginia 23230

Harding, James, Casework Consultant
Missouri Section of Vocational
Rehabilitation
1616 Missouri Boulevard
Jefferson City, Missouri 65101

Hazian, Deron
Department of Social and Rehabilitative
Services
Division of Community Services
Rehabilitative Services
Vocational Rehabilitation
40 Fountain Street
Providence, Rhode Island 02903

Heineman, August, Casework Consultant
Missouri Section of Vocational
Rehabilitation
1616 Missouri Boulevard
Jefferson City, Missouri 65101

Hinga, Kenneth, OSB Regional Supervisor
Department of Social Services
2922 Fuller Avenue, N.E.
Grand Rapids, Michigan 49505

Hobin, John F.
Commission for the Blind
Bureau of Vocational Rehabilitation
39 Boylston Street
Boston, Massachusetts 02116

Hubbard, Guy
Director, Personnel Development and
Continuing Education
Division of Vocational Rehabilitation
Department of Human Resources
P. O. Box 26053
Raleigh, North Carolina 27603

Hughes, Budd, Program Management Officer
Developmental Disabilities Unit
Department of Human Resources
Division of Mental Health
Georgia Mental Health Institute
1256 Briarcliff Road, N.E., Room 402-N
Atlanta, Georgia 30306

Iddings, Curtis
Director
Spinal Cord Injury Project
Woodrow Wilson Rehabilitation Center
Fishersville, Virginia 22939

Jaffee, Dena
Child Consultant
Services for the Blind
1720 West End Building, Room 301
Nashville, Tennessee 37203

Johnson, Darrell T., Director of Rehabilitative Services
South Carolina Department of Mental Retardation
2414 Bull Street
Columbia, South Carolina 29201

Johnson, Harold E., Jr.
Rehabilitation Consultant
Division of Vocational Rehabilitation
610 Asylum Avenue
Hartford, Connecticut 06105

Keate, John
Division of Rehabilitation Services
1200 University Club Building
136 East South Temple
Salt Lake City, Utah 84111

Kohn, Joseph, Director
New Jersey Commission for the Blind and Visually Impaired
1100 Raymond Boulevard
Newark, New Jersey 07102

Kruger, Irving J.
Department of Institutions and Agencies
Commission for the Blind and Visually Impaired
1100 Raymond Boulevard
Newark, New Jersey 07102

Lane, Steve
Assistant Regional Representative
Rehabilitation Services Administration
Social and Rehabilitation Service
1114 Commerce Street - 9th Floor
Dallas, Texas 75202

LaRue, Alfred
Assistant Supervisor in Education
Massachusetts Rehabilitation Commission
296 Boylston Street
Boston, Massachusetts 02116

Lavan, John A.
Assistant Commissioner
Financial Operations
Rehabilitation Services Administration
330 'C' Street, S.W.
Washington, D. C. 20201

Lawrence, Joe
District Supervisor
Division of Vocational Rehabilitation
316 Professional Building
Charleston, West Virginia 25301

Lee, Frank E., Supervisor
Division of Vocational Rehabilitation
1808 West End Building
14th Floor
Nashville, Tennessee 37203

Lenhart, Lowell, Technical Project Director
Department of Institutions, Social and Rehabilitative Services
P. O. Box 25352
Oklahoma City, Oklahoma 73125

Lester, Regina
Pennsylvania Bureau of Visually and Physically Handicapped
Department of Public Welfare
330 Capital Associates Building
P. O. Box 2675
Harrisburg, Pennsylvania 17120

Libby, Bruce, M.Ed.
Director
Elizabeth Levinson Developmental Center
159 Hogan Road
Bangor, Maine 04401

Lillie, Kenneth
Program Planning and Evaluation Officer
Commission for the Blind
535 S.E. 12th Avenue
Portland, Oregon 97214

Little, Curtis O., Supervisor
Staff Development
Rehabilitation Services
1801 Rebsamen Park Road
P. O. Box 3781
Little Rock, Arkansas 72203

Marrero, Elsa, Supervisor
Rehabilitation Center
Box 1681
Rio Piedras, Puerto Rico 00919

Martin, Michael
Division of Vocational Rehabilitation
623 East Adams Street
Springfield, Illinois 62706

Massie, Willman
Chief, Service Systems Branch
Rehabilitation Services Administration
Washington, D. C. 20201

McAllister, Jack, Director
Florida Division of Retardation
100 East Call Street
Tallahassee, Florida 32304

McHugh, Edward
Assistant Director of Training
Massachusetts Rehabilitation Commission
296 Boylston Street
Boston, Massachusetts 02116

Meenach, Leon, Supervisor
Program Coordination & Development
Division of Vocational Rehabilitation
47 Trinity Avenue, S.W.
Atlanta, Georgia 30334

Melillo, Louis G.
Casework Supervisor
Department of Social and Rehabilitative Services
Division of Community Services
Rehabilitative Services, Services for the Blind
46 Aborn Street
Providence, Rhode Island 02903

Merritt, Charles H.
Assistant Commissioner
Rehabilitation Service Operations
Department of Vocational Rehabilitation
4615 West Broad Street
P. O. Box 11045
Richmond, Virginia 23230

Middleton, William E., Program Specialist
Workshops and Facilities Division
Vocational Rehabilitation Department
2303 Devine Street
Columbia, South Carolina 29205

Mills, Craig
Director
Division of Vocational Rehabilitation
725 S. Bronough Street, Room 254
Tallahassee, Florida 32304

Mills, David
Chief, Rehabilitation Facilities Unit
Division of Rehabilitation, Education and Services
801 Bankers Trust Building
Des Moines, Iowa 50309

Minton, Elizabeth B.
Assistant Director of Training
Research and Training Center
Institute, West Virginia 25112

Moriarty, Joseph, Dr.
Director, Rehabilitation Research and Training Center
University of West Virginia
Institute, West Virginia 25112

Murray, Thelma
Director of Staff Development
Office of Vocational Rehabilitation
99 Washington Avenue
Albany, New York 12210

Nagi, Saad Z., Dr.
Professor of Sociology and Public Policy
The Ohio State University, Mershon Center
1250 Chambers Road, Suite 130
Columbus, Ohio 43212

Neeley, Aubrey E., State Supervisor
Vocational Rehabilitation Services
2129 East South Boulevard
Montgomery, Alabama 36111

Nichols, Jerry
Field Services Program Supervisor
Rehabilitation Services for the Blind
1801 Rebsamen Park Road
Little Rock, Arkansas 72203

Pankowski, Joseph M.,
Program Supervisor
Division of Vocational Rehabilitation
725 South Bronough Street
Tallahassee, Florida 32304

Peckham, Ralf
Assistant Superintendent for Vocational Rehabilitation
Division of Vocational Rehabilitation
P. O. Box 1016
Lansing, Michigan 48904

Rawe, Donald
Management and Technical Assistance Branch
Rehabilitation Services Administration
330 'C' Street, S.W.
Washington, D. C. 20201

Redditt, John B., Jr.
Director of Mental Retardation
Tennessee Department of Mental Health
Cordell Hull Building
Nashville, Tennessee 37219

Reeves, Pat
7515 East 17th Street
Anchorage, Alaska 99504

Riley, Larry, Dr.
Research Associate
The Ohio State University, Mershon Center
1250 Chambers Road
Columbus, Ohio 43212

Rhoden, Sally, Acting Assistant
Division Director for Developmental Services
Georgia Department of Human Resources
Division of Mental Health
47 Trinity Avenue, S.W.
Atlanta, Georgia 30334

Rubin, Alvin
Director of Education Services
Ladd School
Exeter, Rhode Island 02822

Rueff, William N., Ph.D., Director
Institute for Developmental Disabilities
Department of Mental Health
P. O. Box 678
Frankfort, Kentucky 40601

Russell, Kenneth
Facility Complex Administrator
Vocational Rehabilitation
6503 Line Avenue
Shreveport, Louisiana 71106

Saunders, Bradley
Program Specialist for Developmental Disabilities
Mississippi Interagency Commission on Mental Illness and Mental Retardation
P. O. Box 16189
Jackson, Mississippi 39206

Sawyer, Perry
Assistant Chief
Rehabilitation Services
New Jersey Rehabilitation Commission
80 Mulberry Street
Newark, New Jersey 07102

Singleton, Guy, Facility Manager II
Vocational Rehabilitation
1542 Tulane Avenue
New Orleans, Louisiana 70112

Sontag, Cooper, Deputy Administrator – Operations
Rehabilitation Services Commission
4656 Heaton Road
Columbus, Ohio 43229

Spears, Marvin O.
Director of Operations
Division of Vocational Rehabilitation
1745 University Avenue
St. Paul, Minnesota 55104

Stancil, Mark, Director
Maryland Rehabilitation Center
2301 Argonne Drive
Baltimore, Maryland 21218

Stubbs, Miriam, Director
Division of Planning and Management Assistance
Rehabilitation Services Administration
330 'C' Street, S.W.
Washington, D. C. 20201

Swearengen, Larry, Program Specialist for Developmental Disabilities
Mississippi Interagency Commission on Mental Illness and Mental Retardation
P. O. Box 16189
Jackson, Mississippi 39206

Tallant, Kyle M., District Director
Division of Vocational Rehabilitation
4809 North Armenia Avenue
Tampa, Florida 33603

Taylor, Don, Assistant Deputy Commissioner for Mental Retardation Services to Children
North Carolina Department of Mental Health
P. O. Box 26327, Executive Offices
325 North Salisbury Street
Raleigh, North Carolina 27611

Tennyson, Doyle B., Assistant Director
Program Assistance
Vocational Rehabilitation Division
P. O. Box 1698
Jackson, Mississippi 39205

Thrasher, Jerry, Administrator
of Mental Retardation Services
Alabama Department of Mental Health
502 Washington Street
Montgomery, Alabama 36104

Waller, Eric R., Supervisor of Training
Vocational Rehabilitation
P. O. Box 44371
Baton Rouge, Louisiana 70804

Wares, Robert, Casework Consultant
Missouri Section of Vocational
Rehabilitation
1616 Missouri Boulevard
Jefferson City, Missouri 65101

Warner, Henry
Assistant Regional Representative
for Rehabilitation Services
Rehabilitation Services Administration
Room 448
50 Seventh Street, N.E.
Atlanta, Georgia 30323

Waters, Richard
Southern Maine Comprehensive Health
Planning
583 Forest Avenue
Portland, Maine 04101

Watson, Harlan C.
Resource Manager
Rehabilitation Education and Services
801 Bankers Trust Building
Des Moines, Iowa 50309

White, Irvin K., Director
Division of Rehabilitation Services
Bureau of Rehabilitation Services
Capital Plaza Towers
Frankfort, Kentucky 40601

Wilcox, Ray
Division of Vocational Rehabilitation
1 West Wilson Street
Madison, Wisconsin 53702

Williams, Norwood, Dr.
Assistant Director of Field Operations
Division of Vocational Rehabilitation
P. O. Box 8717
Friendship International Airport
Baltimore, Maryland 21240

Wolfe, Ann F., M.D., M.P.H.
Deputy Commissioner
Mental Retardation Services
North Carolina Department of Mental
Health
P. O. Box 26327, Executive Offices
325 North Salisbury Street
Raleigh, North Carolina 27611

Woods, Lon
Rehabilitation Services Board
1012 Illinois Building
17 West Market Street
Indianapolis, Indiana 46204

Wurtz, Conrad, Ph.D.
Superintendent
Pineland Hospital and Training Center
Box C
Pownal, Maine 04069

Young, Dell, Director
Sunshine Center
2335 Dandridge Avenue
Knoxville, Tennessee 37915

Young, F. Pat
Case Service Supervisor
State of Idaho
Vocational Rehabilitation Service
209 Eastman Building
Boise, Idaho 83702

Young, Lon, Assistant Regional Director
Texas Rehabilitation Commission, Region II
Southwest Title Building, Suite 207
1320 Lake Street
Fort Worth, Texas 76102

Zawada, Adam R.
Director of Planning and Research
Division of Vocational Rehabilitation
725 South Bronough Street
Tallahassee, Florida 32304